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Agent Guide for Individual Medical Plans

What’s New

In this 9/10 version of the guide?

- Page 6 — A reference to the new Health Access Fundamentals plan was added under the "Agent Resources” section. (Information regarding the Access Fundamentals product will be available in a product-specific agent guide on assuranthealthsales.com.)
- Page 7 — A Health Care Reform Overview was added to summarize the impacts of health care reform on the insurance industry and Assurant Health.
- Page 9 — Multiple updates were made due to health care reform legislation.
- Page 10 — Minor revision to fifth paragraph of the "Other Medical Insurance” section (regarding continuity). We now only require proof of prior coverage for continuity if the applicant is 19 years of age or older.
- Page 15 — Health care reform was added to the list of items that may impact the underwriting decision.
- Page 19 — A table of information was added regarding which plan changes could affect a policyholder’s grandfathered status. In addition, a note was added in the "What You Can Expect” section regarding full pre-existing credit being given to applicants under the age of 19.
- Page 27 — A note was added under the "Eligibility Review” section, indicating that health care reform updates have not been made to the "Eligibility Review” section of EASE. If you are submitting an application for family coverage with an applicant under 19 and the system prevents you from submitting electronically due to an eligibility question, please submit a paper application.
- Page 28 — A note was added under the PAPER PART 1 SUBMISSIONS, "Applicant Instructions” section regarding the time an Individual Medical insurance application will remain valid/open.
- Pages 31 and 32 — The guidelines for Health Access plans have been removed from this guide. Information regarding inforce Health Access Plans A, B and C will be contained in the product-specific agent guide for Health Access plans.
- Page 32 — A note was added to the top of the page indicating that the KeyMed-specific guidelines support inforce KeyMed policies only (since KeyMed is no longer available for new business).

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ABOUT THE AGENT GUIDE

The printed copy agent's guide may not be the most updated version. To view the most up-to-date version, access the Assurant Health Sales Agent Information Site. Refer to the* AGENT RESOURCES *section below for additional information.

For the purpose of this guide:

- "Application" is one of the following:
  - Part 1 (TeleApp);
  - Paper Application;
  - Paper Enrollment Form;
  - *EASE* Application Submission
- "Applicant" refers to applicant and/or enrollee
- "Policy" refers to policy and/or certificate

This Agent's Guide was developed to assist you in marketing our products. It provides answers to many of your questions and directs you to the proper departments within Assurant Health to find answers that may not be in this guide.

This guide contains new business guidelines and provides information about policy administration, billing and coverage changes for all Individual Medical plans. **This guide does not provide product, state specific or field underwriting information.** This information can be found in the State Variations, Underwriting Guidelines and/or the Underwriting Field Guide on the Assurant Health Sales Agent Information Site. Refer to the **AGENT RESOURCES** section below for additional information.

All of our guidelines are not specifically stated in this guide. Our practice is to publish only the most common guidelines. If there are specific underwriting questions that are not answered here, please contact your New Business Service Team. The guidelines listed are merely illustrative of probable action based on our practices and procedures. The Underwriting Department retains the right to deviate from these guidelines based on individual case composition.

AGENT RESOURCES

ASSURANT HEALTH SALES AGENT INFORMATION SITE

Access the Assurant Health Sales Agent Information Site at **assuranthealthsales.com** for information including, but not limited to:

- The most updated version of the Agent Guide
- State Variations
- Underwriting and Administrative Guidelines
- Underwriting Field Guide
- Washington Agent's Guide (for agents selling policies in Washington)
- Product-specific Agent Guides regarding Assurant Supplemental Coverage (Dental, Accident, Critical Illness, or Short Term Disability) or the Health Access Fundamentals plan

MANAGE YOUR BUSINESS WITH MYBOOK™

MyBook provides you with quick and convenient online access to member, policy and billing information for inforce policies (or policies that have lapsed/terminated). In addition, MyBook keeps you up-to-date on the status of your business through alert notices. To receive e-mail alerts, make sure your e-mail address is updated periodically in the Assurant Health Sales site. You can easily search for a particular client or sort and view business according to your management needs. To learn more about MyBook, view the brief training module located in the Agent Library of the Assurant Health Sales Agent Information Site (link above).

HEALTH CARE REFORM OVERVIEW

With the passage of health care reform legislation, we are aware that many questions have arisen regarding the consequences for the health insurance industry and Assurant Health. The overview below was created to summarize the major provisions that affect the underwriting and administration of a policy. Additional information and frequently asked questions (FAQs) regarding health care reform are posted in the Sales News/Health Care Reform News section of assuranthealthsales.com.

The items below are the main health care reform topics that affect the underwriting and administration of an individual medical policy.

Note: For specific underwriting and administrative impacts due to these provisions, refer to the applicable section(s) within this agent guide.

- **Grandfathered policies**: Clients who made the decision to purchase an Assurant Health Individual Medical plan with an effective date on or before March 23, 2010, have "grandfathered" status with advantages in the post-reform environment. Please encourage these clients to keep their plans and specific benefit levels the same if they are satisfied with their plan. These plans are not subject to the potential rate increases that will accompany new plans (those effective March 23, 2010, and later) due to the required expanded benefits and new administrative rules and provisions. Clients with grandfathered policies received a letter in May 2010 that detailed the benefits of having a grandfathered policy.

  If your clients' health insurance needs change and they seek a new plan or want to make changes to their existing plan, it is important to know what changes could impact their grandfathered status so you can help them make the best decision for their situation. Refer to the Policy Changes section of this guide to determine what changes will and will not affect grandfathered status.

- **Dependent coverage extended to age 26**: This provision requires coverage for dependent children to continue until the child turns 26 years of age, regardless of marital status, student status, financial dependency, tax exemption status, residency or employment. Your clients do not need to take any action to keep their young adult children on their plans.

- **No pre-existing condition exclusions for applicants under the age of 19**: For new business effective on or after September 23, 2010, pre-existing condition exclusions are prohibited for applicants (primary, spouse or dependent) under the age of 19. Therefore, we are no longer applying any condition-specific deductibles (CSDs) or special exception riders (SERs) to applicants under the age of 19.

  Note: Inforce plans effective March 24, 2010, through September 22, 2010, are not required to comply with this legislation until January 1, 2011.

  In addition, we can no longer decline applicants under the age of 19 based on medical history (except as add-ons to grandfathered policies).

  Note: Supplemental coverage plans (Assurant Supplemental Coverage and Health Access Fundamentals) are not subject to health care reform.

LICENSING/APPOINTMENT REQUIREMENTS

Each state's rules and regulations dictate under what circumstances an agent may solicit, and an insurer may accept business. At a minimum, you must have an active license in the state in which you are writing the Application for Insurance. Most states also require a company appointment prior to or in conjunction with the solicitation of your first piece of business.

State rules for selling over the Internet (E-commerce) also vary and seem to be evolving. Our practice is to require the soliciting or writing agents to have resident or non-resident licenses and appointments in the resident state of any applicants.

As a licensed agent, you are expected to know the solicitation rules for each state in which you are licensed to sell. If you have any questions regarding resident or non-resident state requirements, please contact License and Contract Support prior to taking your first application.

Assurant Health follows a practice of strict compliance with state rules regarding licensing and appointing agents as it relates to accepting business and paying compensation. Your failure to anticipate these requirements may result in returning applications and the additional need for resolicitation.

Assurant Health only accepts applications that are:

- completed, signed and/or authorized by a currently licensed and appointed agent in the state in which **1)** the product is sold, solicited or negotiated; **or 2)** the applicant is a legal resident.
- for a product type that the company has authorized the agent to solicit.
- for a policy form approved by the state in which the applicant is a resident.
- signed and/or authorized by the applicant on or after the effective date of the agent's license/appointment, **or** after the renewal date. License duration rules vary by state. In applicable states, a copy of a renewed license must be on file with License and Contract Support for us to accept business.
- submitted with a new agent appointment in a state that allows this practice. Call License and Contract Support with questions about specific state requirements. In states where allowed, the Application for Insurance/Enrollment Form and agent appointment should be submitted together and sent to License and Contract Support.
- not altered or corrected with regard to the signature of the proposed insured, the date signed, the city and state or the licensed resident agent's signature.
- actually signed by a licensed and appointed agent; stamped signatures are not acceptable. Applications taken by unlicensed staff, but countersigned by another "licensed" agent are also not acceptable.

General Agents, District Agents/Managers, and Managing General Agents are authorized to recruit and nominate Writing Agents in the states and for the products designated by the Company. They must ensure that every Writing Agent who solicits insurance for Assurant Health:

- is duly licensed by the state in which he/she solicits; **and**
- is properly appointed through the Company; **and**
- is authorized by the Company to submit applications for each type of product.

Submission of business that does not meet these requirements shall be grounds for termination of the General Agent's Sales Agreement and forfeiture of all Rights.

Most states no longer require an appointment for General Agents, District Agents/Managers or Managing General Agents that only receive commission overrides and do not directly engage in selling, soliciting or negotiating insurance. In these states, Assurant Health will not require an appointment unless you notify us that the business activities of your agency require it to be licensed and appointed. This notification must be signed by the principal agent we show on our records and submitted in writing. We suggest you use the Request for General Agency Appointment Form on the agent website at assuranthealthsales.com to notify us. Please check with License and Contract Support if you have a question on the rule for a specific state.

APPLICATION GUIDELINES

ELIGIBILITY GUIDELINES

Refer to the Field Underwriting Guide for Body Build Charts, Medical, Occupational and Hazardous Activity guidelines.

Refer to the State Variation and Underwriting Guidelines for details on state differences.

The documents named above can be found at assuranthealthsales.com.

All submissions of applications, forms and correspondence must be in English.

Age Determination*

All Assurant Health plans are based on the actual age of the applicant as of the effective date.

The minimum age requirement for a primary insured is 19 years old.

- **Adults –** Adults may be written through age 63, under the age of 64.
- **Newborns –** An application may be written for a newborn as soon as the child has had a two-week Well Baby Exam. The initial discharge exam following delivery is not adequate.
- **Dependents –** Dependents can apply for coverage on a parent's plan through age 25.

**Some state variations exist. Refer to state variations at assuranthealthsales.com.*

Children/Sibling Only Policies*

Applications should be submitted with all the following requirements:

- The primary insured must be at least 19 years old.
- The application must contain the signature(s) of:
  — A custodial parent or legal guardian who has knowledge of the minor child(ren)'s full medical history.
  — The owner of the policy if different from the parent or legal guardian (as mentioned above).
  — Dependents 18 years of age or older.

** Not allowed with Assurant Clarity℠.*

Adding an Applicant to an Existing Pending Application

If a new applicant wants to be considered as part of an existing pending application the options for consideration are: 1) Withdraw the pending application and reapply with all applicants included; or 2) Allow the pending application to be issued without the new applicant and reapply to add the new applicant on via an Inforce Underwriting application.

NON-ELIGIBLE PERSONS

The following persons are not eligible for Individual Medical insurance coverage:

- Disabled individuals.
- Those who are currently, or recently have been incarcerated.
- Non-U.S. citizens *(except as described below)*.

  To be considered for coverage, applicants who are non-U.S. citizens must:
  - have a visa or green card.
  - Be able to speak and read the English language, or have completed the application with the use of an Interpreter.

Expectant Parents 19 Years and Older*

**Due to health care reform, the guidelines below do not apply to applicants under the age of 19.*

We will not accept an application for a pregnant female, nor for the father of an unborn child. Coverage for the pregnant mother or the father of the unborn child is not available until the pregnancy has ended. To be eligible for coverage, the mother must have been released from physician care and the baby must have had a two-week well baby exam.

Adoption and Surrogate Pregnancy

Applicants that are currently in the process of adoption or surrogate pregnancy are not eligible for coverage.

After the child is placed in the home and has established care with a physician, they are eligible to pursue coverage through full underwriting.

Other Medical Insurance

Medical insurance should not be written if the applicant has other medical insurance coverage in force (with the exception of Hospital Cash, Daily Benefit plans and Cancer Insurance plans) that the applicant does not intend to replace.

Assurant Health will issue coverage above the military TRICARE/CHAMPUS program but be sure to mention that the applicant is covered by TRICARE/CHAMPUS on the application. Regular underwriting rules will apply. If a claim is submitted, Assurant Health will be the primary payor.

If an illness or injury is covered by a Workers' Compensation plan, Assurant Health does not provide benefits for that illness or injury. No benefits will be provided by Assurant Health for a work-related injury or illness which would have been covered by the Workers' Compensation carrier if an insured was required by state law to maintain Workers' Compensation insurance, but elected not to do so. Assurant Health will provide benefits for a work-related illness or injury if an insured was not required by state law to carry Workers' Compensation insurance and voluntarily elected not to do so.

If this policy is replacing other coverage, we need the name of the other carrier, the effective date, and the termination date of the other coverage. All questions pertaining to other coverage in force need to be answered.

In addition to this information, if an applicant is 19 years of age or older, we require one of the following in states where continuity of coverage is mandated *(subject to state variations):*

- the declarations, summary of benefits, or schedule pages which clearly indicates the prior carrier name, names of those insured, the effective and termination dates of coverage (all plans, except Health Access) or paid through dates and type of plan (Individual, Group, Cobra etc.); **or**
- a copy of the Certificate of Creditable Coverage.

MEDICAL CONDITIONS

Refer to the Field Underwriting Guide, at assuranthealthsales.com, for a list of medical conditions that may or may not be considered.

Medical history that occurred more than 5 or 10 years ago *(state/product variations may differ in time frames)*

It's important to keep in mind that the application asks for diagnosis treatment and/or consultation within the past five or ten years. Any continued consultation within that time period, regardless of the date of onset or date of initial diagnosis for a condition, should be disclosed.

Genetic Disclosure:

Assurant Health does not use or collect genetic information for any underwriting purpose. Genetic information includes information related to genetic tests, genetic counseling, and any family history of a disease or disorder. If any such information is inadvertently provided by the applicant, it should not be included on an application or communicated to Assurant Health in any manner.

PREFERRED RATES

Qualifications

An applicant qualifies for preferred rates if:

- 18 or older and not a dependent child.
- Build falls in the preferred range.
- Tobacco free for three years or more.
  - o Smokes less than 10 cigarettes a day or less than 2 cigars or pipes a day.
- No Driving Under the Influence (DUI) citations in the past two years.
- No more than one moving violation in the past two years.
- Cholesterol is under 221 or over 221 with a ratio of 3.5 or less
- Blood pressure is under 141/91.
- No ratings, riders or CSDs. (some exceptions apply)
- The drug card deductible after underwriting is less than $500 for brand or $300 for generic.
- 39 or younger or has had a physical exam within the past three years.

Applying

To apply for preferred rates:

- Submit a quote with preferred rates included.
- Manual/Paper submissions should submit the Preferred Questionnaire.
- Electronic submissions will be considered for preferred rates upon call in of the medical interview or during the online submission process.

CALCULATING RATES/QUOTES

You can download the software or run quotes on our *EASE* online system from assuranthealthsales.com.

You must include a software illustration/quote with all applications. Make certain that if premium is submitted with the application, that it matches the software illustration.

Currently Insured

Select the appropriate answer (yes/no) to the Currently Insured question. By selecting yes you are confirming that the applicant has been covered by health insurance for the last six months from the policy effective date without an interruption in coverage of more than 60 days. Proof of coverage may be required as part of the underwriting process or subsequent to policy issue.

Health insurance coverage is defined as medical insurance and does not include accident, critical illness, disability or other supplemental plans. Short Term Medical and Health Access plans do qualify as prior health insurance coverage.

Rates quoted more than 30 days in advance of the effective date are subject to change and are not guaranteed. The proposal is not an insurance contract. Only the actual contract provision will apply. Final rates may vary slightly due to the rounding process.

Non-Tobacco User Discount

To qualify for a Non-Tobacco User Discount, each eligible person must attest, during the application process, that he/she has not smoked cigarettes or used tobacco in any form, including nicotine replacements (i.e. Nicotrol NS (nasal spray), Nicotrol Inhaler, Nicoderm CQ, and Nicorette, or any other nicotine replacement) within the past 12 consecutive months, in addition to fully completing the entire application.

The Underwriting Department reserves the right to verify non-tobacco user information with the proposed insured directly and may request a specimen to test for the presence of nicotine. The presence of nicotine in the specimen will disqualify applicants from receiving a Non-Tobacco User Discount and Preferred Rates.

IMPORTANT INFORMATION FOR YOU AND YOUR CLIENT

- Assurant Health relies on your client's answers to the application questions, and their answers have a significant impact on their eligibility for insurance. Your client should respond to the application in a thorough and complete fashion because this information is relied on by Assurant Health. Information that is not completely and accurately disclosed may result in the rescission of coverage.
- If your client provides you with any health history information, you are required to fully disclose that information with the application. Do not make a determination about the significance of the information. Assurant Health underwriters will determine what information is relevant during the underwriting process.
- Assurant Health does not automatically order medical records for every case. The client should disclose their full and complete medical information and not assume that medical records will be ordered.
- Obtaining accurate child height and weight information is very important. The application process will be delayed until the information is received.
- Obtaining all the required authorizations at the time of application submission is critical to begin the underwriting process.
- Clients should contact Assurant Health if they think of any additional information that should be disclosed.
- **For applications in the state of California (CA):** Where you assist in the submission of an application, you must sign the application attesting to the following: that to the best of your knowledge, the information on the application is complete and accurate; that you have explained to the applicant, in easy to understand language, the risk to the applicant of providing inaccurate information and that the client understood the explanation; and that you understand that if you willfully state as true any material fact you know to be false, you will be subject to a civil penalty up to ten thousand dollars in addition to any applicable penalties or remedies.

Note: To assist you and your client with completing the application, an Agent Checklist and Applicant Checklist are available on the Assurant Health Sales Agent Information Site at: assuranthealthsales.com. Please use the Agent Checklist and provide the Applicant Checklist to your client **every time** you complete the application process to ensure we obtain all the information needed to process the application.

BILLING

Is it possible that a specimen could be positive for nicotine just because the applicant was in an area with smokers? No. Our test levels are high enough to exclude any passive smoke.

MEDICAL EXAMINATIONS

Paramedical examinations may be required based on the underwriter's discretion. If an exam is required, the home office will order the exam for your applicant through one of our preferred vendors.

Note: A signed and dated Underwriting Authorization form is required. Please obtain written authorization from all applicants 18 years or older and retain the form on file should a request for additional medical information be required.

FIRST PREMIUM

The agent is responsible for collecting the full first premium.* If no premium is submitted, the policy will be considered Cash On Delivery (C.O.D.) and the insured will be billed.

**If payment mode of electronic funds transfer (EFT) or credit card is requested, along with all information to process the billing of EFT or credit card, a check for first premium does not need to be submitted.*

Checks and/or money orders should be made payable to Assurant Health. Checks and/or money orders made payable to an agency will be returned.

Checks submitted with an application should have the same date the application was signed. If we receive a post-dated check, the application will be treated as C.O.D.

Applications can be sent C.O.D. A bill will be sent with the policy. C.O.D. applications will not receive a effective date that is earlier than the date of issue.

In cases where the full premium is not paid at the time of application, a tolerance of 80% of the premium due (not to exceed $100) will be applied. This means that if the payment falls within this tolerance, the premium will be applied to the policy, the agent's commission will be paid on the total amount due, and the balance will be billed to the insured at the next billing cycle.

If no premium, or less than the tolerance amount is received with the application, the Conditional Receipt will not apply if on Direct Bill. We will mail a bill along with the policy to the insured. Policies on EFT will draft as soon as the policy(ies) are released by the Underwriting Department, even if the premium is not due until the following month. In these cases, no commissions will be paid until the premium is received.

PAYMENT MODES

- Direct billing for quarterly, semi-annual and annual modes.
- Monthly/multiple electronic funds transfers (EFT)
- Credit card
- List bill

DIRECT BILLING

Quarterly, semi-annual and annual payment modes are direct billing methods. Monthly direct billing is not available.

On direct bill policies, premium notices are mailed as early as 35 days prior to the due date, and include adjustments for past due premiums, underpayments and overpayments, as well as additional charges or credits due to a policy change.

ELECTRONIC FUNDS TRANSFER (EFT)

Electronic Funds Transfer (EFT, formerly Check-O-Matic) is a convenient billing method by which premiums are automatically drawn from the payor's checking account. Premiums can be drawn on any day except the 29th, 30th and 31st.

Policies on EFT will draft as soon as the policy(ies) are released by the Underwriting Department, even if the premium is not due until the following month.

If EFT is requested, be sure to complete a Bank Draft Authorization,* including routing, transit and account numbers. The authorization gives Assurant Health the authority to draft the premium payor's account for premium due. A copy of a voided check is helpful in verifying the appropriate information.

**Authorization types differ depending on the submission type of the application.*

If the above requirements are not received when EFT is requested, we will issue on direct bill quarterly mode.

MULTIPLE ELECTRONIC FUNDS TRANSFERS

The capability exists in many states to debit multiple individual policies on one EFT account, with a maximum of 18 policies per EFT account. This will help to facilitate the administration of payment of individual policies where the employer is collecting the premium from the employee through payroll deduction. The employer should have one common draft date for all policies, even though the effective dates differ.

**Multiple EFT can only occur in those states that allow payroll deduction. In addition, the multiple EFT group must also qualify per the state's Employer Sponsored Business (ESB) Requirements. Please see the Underwriting and Administrative Guidelines (assuranthealthsales.com) for more information and to determine the guidelines for your state.*

EFT Draft Date

The EFT draft date and the policy effective date should coincide, if possible. This ensures that the premium is drafted on the same day of the month that the policy was effective.

EFT Premium Payments

Even if the applicant's policy is not yet issued, the agent should encourage the payor to record regular debits from his/her checking account each month. This will help to reduce NSF checks since the first EFT withdrawal will cover all due premiums other than the first.

CREDIT CARD

Payment by credit card will be available to applicants for ***initial premium payment or recurrent premium payments.*** Premium to pay the policy to a current date will be charged to the credit card as soon as the policy is activated. Subsequent premiums will be billed by direct bill, EFT or credit card.

MasterCard℠ and VISA® will be the only cards accepted.

Existing policyholders will be able to take advantage of a one-time credit card payment option by contacting the Policyholder Service Department. Any premium due will be charged to a credit card rather than being collected by the current billing method.

To set up credit card billing, we require the credit card information and authorization* by the cardholder to draft their account.

Required credit card information includes:

- Card type: Visa or MasterCard
- Expiration date
- Name of cardholder as it appears on the credit card
- Signature of the cardholder
- Credit cardholder address, if different than the policyholder address
- Subsequent billing type and all necessary information *(see payment modes in previous section)*

**The method by which authorization is obtained will differ depending on the submission type of the Application/Enrollment Form.*

LIST BILL — *Refer to the List Bill Agent Administrative Guide for additional details (Form 29240)*

List bill enables an employer to payroll deduct premium for individual medical coverage purchased by their employees. Employers do not contribute any monies towards the payment of these individual medical plans. Employees pay 100% of the medical premiums.

The following are features of the list bill option:

- list bill accounts are billed monthly to the list bill accountholder (employer) on a combined bill.
- Employers will select their billing due date. The due date must be between the 1st and the 28th of the month.
- Employers will be able to submit one check that incorporates all of the employee's premiums that are due.

The employer must complete a List Bill Account Agreement Form to establish a list bill account.

The availability of the list bill option is based on the physical location of the employer.

BILLING MODE CHANGES

Requests to change billing modes following the issue of the policy should be directed to Premium Services, not the Underwriting Department.

EFFECTIVE DATE RULES

EFFECTIVE DATE

A space is provided on the application for the requested effective date. The effective date will be the later of:

1. The date after the application is signed or the day after an electronic application is submitted.
2. The future date that the applicant requests; however, no policy will be dated on the 29th, 30th or 31st of any month. Applications completed on these days should have a requested effective date no earlier than the first of the following month.
3. The termination date of any insurance to be replaced. *The termination date of any applicant's prior medical insurance coverage and the effective date of the new medical plan should be the same. This rule is applicable in a replacement situation, including the replacement of a previous Assurant Health policy.*

The earliest date a policy can have is the day after the application is signed; backdating is not permitted. We will not date a policy more than 10 days prior to the date that the application is received at the Home Office, nor accept an application with a requested effective date more than 45 days in advance. Applications dated more than 45 days prior to the requested policy date will be closed out. In addition to the above dating rules, C.O.D. rules will apply.

CONDITIONAL RECEIPT

The Conditional Receipt, which is included in the application, provides coverage prior to actual policy delivery, providing that the following conditions are met:

1. The full premium must be collected (except if EFT or credit card information is received) and submitted with the application and a Conditional Receipt must be issued. Partial premiums are not allowed. Coverage will be provided in accordance with the Conditional Receipt for everything but pre-existing conditions. The Conditional Receipt will be effective either the date the application was signed/submitted plus one day, or the requested effective date, whichever is later.
2. Paper applications must be received within 10 days of the applicant's signature date. For the TeleApp/EASE process, a health history interview must be completed or responses to online health questions must be submitted within 10 days of the receipt of the TeleApp Application or the EASE online submission date.
3. The proposed insured must be an acceptable risk to Assurant Health under our rules, standards and practices for the exact policy and premium applied for, without any modification.
4. The proposed insured must agree to complete all forms and provide all information required through the enrollment process. This includes the Acceptance of Offer and Attestation for TeleApp applications.
5. The policy must be issued exactly as applied for within the application. If the application is not issued within this time, the Conditional Receipt will not apply.

If the premium is collected and a Conditional Receipt is given, coverage will be offered and made effective the date the application was signed plus one day, provided the applicant was insurable at the time. All policy provisions apply (e.g., pre-existing conditions).

If the application is submitted on a C.O.D. basis, or if the application is pending underwriting approval beyond the 30 days provided by the Conditional Receipt, the policy will be dated when the application is approved. No coverage will take effect until the policy is delivered to the insured, the first premium is collected, and all further requirements (Amendment of Application/Statement of Health and Insurability; Special Exception Rider; or a CSD endorsement) have been properly completed.

UNDERWRITING PRACTICES

Appropriate risk selection is critical to maintaining stable rates and providing quality benefits.

UNDERWRITING OUTCOMES

The underwriting process will produce one of the following outcomes:

- **Standard/Preferred offer –** you will receive the policy in the mail for placement. TeleApp applicants must sign and return to Underwriting the Acceptance of Offer and Attestation.*

  **Oregon residents will receive Certification of Completion and Correctness.*
- **Requests for requirements for medical records, labs and exams and/or forms** – you will receive notification on your ***EASE*** status report.
- **Counter underwriting offers** will be posted on ***EASE*** before the policy is issued so your customer can review the offer. Any additional delivery requirements must be signed and returned to Assurant Health. TeleApp applicants must sign and return the Acceptance of Offer and Attestation to Underwriting.*

  **Oregon residents will receive Certification of Completion and Correctness.*
- **Declined underwriting notification** – you will receive notification via mail or ***EASE***.
- **Postponements –** underwriting decision that we cannot offer coverage at this time but could reconsider at a later time. Details of why an applicant was postponed will be provided, along with time frame and what is needed to reapply.

  If we receive additional information that allows us to issue after we've postponed, and the information was received within 60 days (30 days for Health Access) of the signature date of the original application, we will reissue the policy with the applicant added. If the information received is beyond 30/60 days the applicant can submit an Inforce Underwriting application for consideration to be added on the original policy.

State Variations that May Affect Individual Medical Underwriting

Ability to rider, apply Condition Specific Deductible, or rate, may be limited and may impact the underwriting decision.

Other Items that May Impact the Underwriting Decision

- Health care reform
- Cost of medications
- Frequency of office visits
- Potential surgery
- Progression of disease – acute vs. chronic/degenerative
- Plan benefit selection

Rating a Dependent Child

If a dependent child needs to be rated for a medical condition, in most cases we are able to keep a child with a rated premium on the parent's policy. However, there are instances where the child may need to be placed on a separate policy. This offer is on an individual consideration basis. Agents are not able to add this rating using quoting software as this is done internally by the underwriter. The new family premium will be communicated by Underwriting at the time of the counteroffer.

CONDITIONAL ISSUES

Special Exception Rider, Condition Specific Deductible (CSD) and Amendment Forms

When the forms outlined below accompany a conditionally issued policy, or information regarding a conditionally issued policy, the form(s) must be completed upon delivery.

Special Exception Riders are used to exclude known pre-existing medical impairments or avocational interests from coverage.

Condition Specific Deductible Amendments are used to acknowledge the issuance of a policy with a condition that has a specific deductible separate from the policy deductible.

Note: Special Exception Riders (SERs) and Condition Specific Deductibles (CSDs) are not available for Individual Medical applicants under the age of 19.

Amendments of Application are used to:

- acknowledge changes to information on the Application for Insurance.
- acknowledge the issuance of policies with ratings in some situations.
- require the proposed insured to acknowledge any change in health or occupation since the date of the application.
- verify missing information.
- delete an applicant.

In any of these instances, policyholders and applicants over 18 years of age should sign and return a copy of each required form to the Underwriting Department within 10 days. **If there is a change in the health or**

occupation of the proposed insured, delivery of the policy is not authorized. Such policies should be returned immediately to the Home Office with a complete explanation.

If a policy is issued with a Special Exception Rider or Condition Specific Deductible, a review notice letter will be sent to the policyholder and agent when the review date has expired. This notice will provide as a reminder that the policyholder has the option of submitting an application to our Inforce Underwriting Department *(see In Force Policy Changes section)* or doing nothing.

AGENT COMMISSION IMPACTS

When an applicant applies for a new IM plan and has had previous Assurant Health IM coverage inforce , and the prior plan had a minimum duration of at least four months within the last 60 days, the agent will be compensated at internal replacement commission rates rather than new business rates.

Determination of gaps will be made by the most recent active IM policy termination date and the new IM policy effective date.

NOT TAKEN POLICIES

A **10-day Free Look** provision is provided on all policies. Should an applicant decide their policy does not meet their needs within this time period, they may return the policy and request, in writing or by phone, to have the policy marked NOT TAKEN. All paid premium will be refunded.

Not taken requests will be granted within 10 days of the policy delivery date.

Requests received beyond 10 days of the policy delivery date will be handled as a request to terminate a policy as of the request date and any refunds would be calculated to that date.

REISSUES

Reissue requests are subject to underwriting approval based our guidelines and practices.

We will consider requests to reissue in-force policies if we receive the request within 30 days of the policy issue date. If we receive a policy change request, and the requested date is more than 30 days after the issue date, refer to the *Policy Change Rules* section.

A request to change the effective date of an in-force policy is a reissue. A request to change the effective date once the policy has been issued will not be considered if the applicant had no prior coverage and received a Conditional Receipt. Making this change could result in a change of premium rates. We will not accept requests to backdate the effective date of coverage.

MEDICAL RECORDS

Very few of our applicants require medical records as we expect to receive very accurate and complete information during the application process. We order medical records for a very limited amount of applications received; ordering records for every applicant would delay the underwriting process and it would be cost prohibitive.

Note: A signed and dated Underwriting Authorization form is required. Please obtain written authorization from all applicants 18 years or older and retain the form on file should a request for additional medical information be required.

CONFIDENTIALITY AND RELEASE OF INFORMATION

If the applicant requests the reasons for an adverse decision, when it is due to confidential information, the following procedures must be followed:

1. The applicant may call, mail and/or fax a written request to the Home Office asking that the confidential information be disclosed or sent to themselves or their medical practitioner (if they so choose). If the request is by phone from the primary applicant, we will ask him or her to verify the following information before releasing information due to HIPAA regulations:
   - Policy number
   - Social security number or last four digits of the primary insured's/covered person's social security number
   - Full name of primary insured or the covered person
   - Date of birth of primary insured or the covered person
   - ZIP code
2. If submitting the request in writing, the applicant must sign the request and include the complete name and address of the person that the information should be sent to.
3. Upon receipt of the request, the Underwriting Department will disclose the information on which the decision was based. To maintain confidentiality, we will not fax responses.

LEGAL REQUIREMENTS

OUTLINE OF COVERAGE REQUIREMENTS

Some states have a legal requirement to provide the state-approved Outline of Coverage to the applicant at the point of sale. Refer to the appropriate State Variations to determine if an Outline of Coverage is required.

State-specific Outlines of Coverage define mandates and other differences in coverage specific to those states. Please make sure the correct Outline of Coverage is delivered to the applicant.

REPLACEMENT

Certain states have adopted specific requirements that must be followed in the event that another company's individual health insurance plan will be replaced by an individual Assurant Health plan. Those states have replacement regulations and require replacement forms. Refer to the Underwriting Guidelines for your state to determine if a replacement form is required.

RESIDENCE REQUIREMENTS

Applicants are eligible for health insurance if they are citizens of the United States, or are foreign residents living in the United States under a form of immigrant visa. Non-immigrant aliens or those U.S. citizens maintaining or anticipating residence outside the continental United States are not eligible for health insurance.

INELIGIBLE RESIDENT STATES

Residents of the following states are ineligible for individual medical coverage with Assurant Health:

- Hawaii , Maine, Massachusetts, New Jersey, New York, Rhode Island, and Vermont

FAIR CREDIT REPORTING ACT

Federal law requires that a notice be given to any applicant experiencing adverse action. The notice states that a consumer report was reviewed as part of the underwriting process. This would include consumer reports from MIB and a credit reporting agency.

NOTIFICATION REGARDING MIB

MIB Inc. is a reporting agency that provides insurance carriers with information regarding past reported medical information.

The general rules of MIB Inc., of which Assurant Health is a member, require that each applicant for insurance be given prenotification regarding MIB and specifically that MIB Inc., upon request, will supply Assurant Health with information in its file. Assurant Health may also release information to MIB Inc. This information is part of the Application/Enrollment Form for insurance.

Applicants and/or consumers can request any reported information on the internet at mib.com or by calling 866.692.6901.

NOTIFICATION REGARDING CREDIT SCORE REPORTING

CSC Credit Services, Inc. is a credit reporting agency that provides insurance carriers with information regarding past reported credit information.

Applicants who receive notice that an adverse action occurred due to credit score during the underwriting process will be instructed that they can request a copy of their credit report on the internet at csccredit.com, by calling 800.759.5979 or the request can be mailed to:

CSC Credit Services
Attn: Consumer Processing
PO Box 619054
Dallas, TX 75261-9054

They are also instructed on their right to challenge any information contained in the report.

NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy, Assurant Health needs to obtain information about persons proposed for insurance. Some of this information will come from the application and some will come from other sources. All information collected by Assurant Health may, in certain circumstances, be disclosed to third parties without the proposed insured's specific authorization. The proposed insured does have the right to access and correct the information collected which may relate to a claim, or civil criminal proceeding. The notice is part of the Application/Enrollment Form for insurance.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) sets forth minimum standards for the availability of individual medical policies on a guaranteed issue basis with no pre-existing condition limitation for qualifying eligible individuals.

If you have a client who wishes to obtain coverage on a guaranteed issue basis with no pre-existing

limitations please see the Underwriting Guidelines, at assuranthealthsales.com, for details.

HIPAA PRIVACY

As a business associate of Assurant Health and as a representative working on behalf of each applicant, it is your responsibility to protect the confidential information you collect. HIPAA privacy and security regulations require that you, as a business associate, have the physical, administrative, and technical safeguards in place to protect this information. Please refer to the Assurant Health privacy policy at www.assuranthealth.com to understand how protected health information is handled at Assurant Health and information on how insureds can exercise their individual rights under HIPAA. Please contact the Assurant Health Privacy Office immediately if you are aware of any breach of protected health information.

STATE HEALTH INSURANCE PLANS

In order to provide coverage for people who are unable to purchase satisfactory medical insurance through private insurers, states have enacted State Risk Pool plans. For details regarding these types of plans, please refer to the Underwriting Guidelines at www.assuranthealthsales.com. Generally, people who have been declined, charged an extra premium, or issued coverage with a Special Exception Rider, are eligible to obtain coverage through these plans. Many states also require insurers to notify applicants of their eligibility to apply for coverage under these plans.

People who wish to obtain coverage through a State Risk Pool plan must usually submit evidence that they have been unable to acquire coverage through private insurers, or unable to obtain coverage without Special Exception Riders. Assurant Health will assist an applicant in this regard. In order to do so, we require that a fully-completed paper application be submitted to our office *(EASE submissions cannot be used for this request)*. Please advise us by a separate memo or note, directly on the Application/Enrollment Form, stating that the application is being submitted for purposes of qualifying for coverage under a State Risk Pool plan.

If the risk pool is the state's guaranteed issue plan for HIPAA eligibles, a letter of declination from a private insurer is not required.

NOTE: It is important that no money is collected, and no Conditional Receipt is issued on these applications.

POLICY CHANGES

Policy changes on the Assurant Clarity℠ plan design may be restricted if there is an outstanding balance that is past due. Once the outstanding balance is paid in full to Assurant Health, the requested policy change can be considered.

PLAN CHANGES — IMPACTS TO GRANDFATHERED STATUS

It's important to understand what plan changes could remove the grandfathered status of a policy. Refer to the table below to determine what policy changes could impact your customer's grandfathered status.

Changes That Will Remove Grandfathered Status	Changes That Will Not Remove Grandfathered Status
Termination of existing plan (even to purchase a new Assurant Health plan) including: • Internal replacements • Guaranteed conversions • New business	Reinstatements with the same plan/benefits within 6 months of termination (and **no** adverse action is applied)
Plan lapses due to nonpayment	Decreasing the deductible or coinsurance
Increase in deductible or coinsurance	Removal or addition of: • Dental/Vision or any Dental benefit • SuiteSolutions • Accident Medical Expense (AME) • Life • Spouse/dependent
Removal of maternity rider or other optional riders (except as noted in the right-hand column)	Removal of Office Visit Copay
Plan/form number changes	
Adding the Office Visit Copay	
Reinstatements (of grandfathered plans) where adverse action is being applied	

Note: This list is subject to change.

GUARANTEED CONVERSIONS

An eligible person may request a conversion of coverage if they are no longer eligible for coverage due to a:

- Divorce
- Death of the primary insured
- Dependent who no longer meets eligibility requirements

Requests must be made within 60 days of termination.

Evidence of Insurability is <u>not required</u> if applying for equal/similar benefits. A manual application submission (Enrollment Form or Teleapp) is required with eligible person's name, demographics and billing selection/requirements. Only the tobacco question (except KeyMed) needs to be answered. Applicants age 18 years and older who are applying for the conversion must sign the new application. Assurant does not require full medical disclosure or quotes. Prior adverse action will be carried over.* Agent information is required on the application.

** If a fully completed application is received and the original policy has a special exception rider, condition specific deductible or a rating, we will underwrite the adverse action for consideration to remove, reduce or carryover to the conversion policy.*

All applicable new business forms (i.e. Replacement forms, HSA etc.) are required except:

- Employer Sponsored Business and Colorado Group of One forms.

Evidence of Insurability <u>is required</u> if: applying for better benefits. A fully completed application is required using any submission type with full medical disclosure. The request will be fully underwritten.

What you can expect:

- The policy will be dated as of the termination date of the original policy. Assurant will not allow a gap in coverage.
- Pre-existing credit will be given based on the amount of time the insured has been on the prior policy.

  Note: Full pre-existing credit will be granted to all applicants under age 19.
- Deductibles, Coinsurance, lifetime/policy maximums will carryover to the new policy (except: if transferring Non KeyMed plans to/from KeyMed plans).
- Processing Fee will be waived.
- Commission rate is 10% for guaranteed conversions.
- If the applicant submits an application for a conversion without agent information included on

Policy changes on the Assurant Clarity℠ plan design may be restricted if there is an outstanding balance that is past due. Once the outstanding balance is paid in full to Assurant Health, the requested policy change can be considered.

the application, no agent will receive commission on the conversion application.

- We cannot process add-on dependents with a conversion due to different dating rules. We will process the conversion application first and then a Inforce Underwriting request can be submitted to consider the addition of the dependent.

INTERNAL REPLACEMENTS

An internal replacement is a request to replace an existing active IM policy that has been in force for at least 12 months with a new Individual Medical policy without a gap in coverage.

When should you offer a replacement policy:

- Customer has been given options to make changes to existing plan but replacing is the only option agreed upon.
- You are at risk of losing your customer.
- Customer is interested in a new form/plan (e.g. has Preferred plan would like a Portfolio plan)

Submissions for Internal Replacements include two types:

1) Fully completed application: Use new business submission methods (i.e. EASE, manual submission)
   a. Policy must be inforce a minimum of 1 year
   b. Quote/Proposal is required
   c. Forms that are required for New Business submissions are required for this submission.
2) Simplified process: Use the Assurant Health Sales Website to verify if eligible for this submission type. If eligible, the simplified form can only be submitted using mail, fax or email to MKE.UWTechs@assurant.com.
   a. KeyMed, Assurant Clarity℠ and HIPAA policies are not eligible for the simplified submission process.
   b. All individuals replacing must be inforce a minimum of 2 years without a gap in coverage (except dependents added as of their date of birth or adoption)
   c. Current policy can not have any active Riders, Conditional Specific Deductibles or Ratings.
   d. Must be applying for the same risk class as current plan (e.g. standard, preferred, smoker).
   e. The total premium for the current policy must be less than the total premium for the proposed replacement policy.
   f. All applicable new business forms (i.e. Replacement Forms, HSA, etc.) are required except:
      - Colorado Group of One forms

Effective Dates rules for Internal Replacement

- Assurant will not allow a gap in coverage
- The day/date will be equal to the current plan's effective day/date

  (e.g., if the current plans effective date is 3/2/04, the new effective date will be the 2nd of the month).
- The month will be determined using the earliest month quoted or the month of the paid thru date of the original policy

  (e.g., if the current plans effective date is 4/15/06, the paid thru date is 9/15/07, and quote indicates 10/15/07 the effective date issued will be 9/15/07).

What you can expect:

- Any premium credit or debit amount on the current policy will be transferred to the replacement policy.
- Pre-existing credit will be given based on the amount of time the insured has been on the prior policy.
- Deductibles, Coinsurance, lifetime/policy maximums will carryover to the new policy (Exception: If transferring Non KeyMed plans to/from KeyMed plans).
- Processing Fee is applicable.
- Commissions are paid per renewal schedule.
- If the prior policy is terminated and the replacement application is signed "after" the termination date, Assurant will treat as new business and not as an internal replacement.

NOTE: The states of California and Idaho differ greatly regarding internal replacements. Please reference these states' Underwriting and Administrative Guidelines found on assuranthealthsales.com.

INFORCE DEDUCTIBLE OR COINSURANCE CHANGES

Changes in deductible and/or coinsurance, that result in a decrease of premium, can be processed with a written request or phone call to the Policyholder Service Desk from the primary insured or agent.

INFORCE UNDERWRITING

Inforce Underwriting handles requests for changes on existing policies that require underwriting. Changes Inforce Underwriting handle are:

- **Changing of benefits that result in an increase in premium**
- **Adding Preferred Rates**

- **Addition of Maternity**
- **Addition of the Office Visit Copay**
- **Additions of any applicant(s) previously postponed during the initial new business application process.**
- **Addition of spouse, dependent(s), and/or newborns**

  If a newborn is being added to a child only policy the newborn must have had a two-week well baby exam prior to applying.

  A newborn child or adopted child being added to a primary insured or spouse while the policy is inforce, will be covered for 60 days from the date of birth or placement for adoption. To continue coverage beyond the first 60 days, Assurant Health must be notified by phone or in writing within 60 days of the newborn's date of birth, or the adopted child's date of placement. If the request for coverage is received more than 60 days, an Inforce Underwriting application should be completed and submitted to Inforce Underwriting for consideration of coverage.
- **Removal or reduction of Special Exception Riders, Condition Specific Deductibles, Special Class Premiums, Modified Benefit Endorsements or Tobacco User Rates**

  We will accept application only after the policy has been in force for 12 months or more or after the date noted on the amendment/rider.

  The reduction and/or removal of a Special Class Premium or Tobacco User rates is not solely dependent on the resolution of the condition for which the special premium was initially placed.
- **Reinstatements**

  Reinstatement is a request to place a terminated policy back in force with a gap in coverage.

  Policy cannot be lapsed for more than 6 months.

Submissions for Inforce Underwriting Requests

A fully completed application submitted via, mail: Attn: Inforce Underwriting, PO Box 551, Milwaukee WI 53201-0551 or Fax to: 414-299-8811

Premiums should not be sent as they do not bind coverage.

What you can expect:

- All requests are fully underwritten. Any change in health history since the initial application will be taken into consideration when assessing the change request.
- Coverage will take effect upon approval from the Inforce Underwriting area and will not be backdated.
- We will bill for additional premium if the requested changed is approved.
- Adding a spouse or dependent does not earn additional commissions

NOTE: The states of California and Idaho differ greatly regarding internal replacements. Please reference these states' Underwriting and Administrative Guidelines found on assuranthealthsales.com.

We will charge any additional premium required during a 60-day period with the exception of Kentucky, Montana and Vermont, where newborn coverage is free for the first 31 days from birth; and Florida, where newborn coverage is free for the first 60 days from birth.

DEPENDENT GUIDELINES

Under the provision of each health policy, dependents remain eligible for coverage under their original policy:

- as long as he or she is unmarried. (Appropriate rates will be charged).
- as long as he or she is considered disabled. An insured dependent will be considered disabled if the dependent cannot engage in any substantial, gainful activity because of his/her physical or mental condition.

*** This includes covered dependents over 18 that may no longer be a full-time student.*

NOTE:

- These provisions may vary based on state and/or policy form number.
- A covered dependent is eligible to convert to another plan when they no longer meet the eligibility requirements
- It is the responsibility of the insured to notify Assurant Health when dependents no longer qualify and need to be removed from the policy.

ADDRESS CHANGES

Follow this procedure for quick and accurate processing. If calling in an insured's address change, please have the following information ready:

- Insured's name
- Policy number
- Old address
- New address, including ZIP code
- Telephone number
- Temporary or permanent address change?

It is important that you remember to list ALL policies involved in an address change, especially if there is EFT or List Billing.

NOTE: Be especially careful of electronic funds transfer (EFT) billing where the payor address is different than the insured's.

Will a change of address affect my premium?
A change of address may increase or decrease your premium. Notification will be sent to the insured and agent when the address change is made.

STATE RESIDENCY CHANGES

If an existing customer relocates from one state to another, their policy will be affected. Upon notice of the residence change, the customer will receive a notice from us as to how their policy will be affected. Each situation and state is treated individually based on the circumstances.

NON-SUFFICIENT FUNDS (NSF)

A check is submitted twice before it is returned to Assurant Health. If the check does not clear the second time, the insured will be notified by letter that the check was returned and the insured must submit a new check. The insured is given 20 days from the date of the letter to submit the premium. If the policy is on EFT, the insured or agent can call the Policyholder Service Desk within 20 days to redraw the account. If a replacement check is not submitted, or the account is not redrawn, the policy will lapse 30 days from the date of the returned item.

BANK CHANGES FOR ELECTRONIC FUNDS TRANSFER (EFT)

In writing:

Obtain a new, signed EFT Authorization and voided check for the new bank account. Allow 30 days advance notice on all changes to an existing EFT account. On a bank change, it is important that the client leaves his/her account open for 30 days and leaves one month's premium on deposit for each policy in the old account.

By phone:

The caller must be the checking account owner or an authorized signatory on the account. If the account routing number begins with a 5 or 9, the account holder must contact the bank to verify the correct routing number for Automated Clearing House (ACH) transactions.

Both:

If we drafted the old account, prior to receiving the new account information, and the draft is returned unpaid, we will automatically redraw for the premium due at the new bank.

If a draft on a new account is returned unpaid, a letter is generated stating that the premium should be submitted within 20 days or a call should be made to the Assurant Health Policyholder Service Desk to request that the account be redrawn.

Multiple Policies:

If the bank change only affects some of the policies (the balance of the policies are to continue drafting from the present bank), list only the policies involved in the change.

** See the Billing Section for additional information regarding Multiple EFT and Employer Sponsored Business (ESB) requirements.*

Draft Dates

Draft dates can be any date between the 1st and the 28th of the month. Premiums are drafted in the month they are due.

Balance Due

Additional premium due for a change to an EFT policy will be drafted on the next available draft date (1st to the 28th).

Premium Change

Whenever there is a change in the payor's bank information, or in the premium amount from the prior draft, the Federal Reserve Board requires that the draft be warehoused for 10 days. Assurant Health will send the agent and the premium payor a letter when the draft amount is changed. In these situations, the draft from the premium payor's account will not be processed until approximately 10 days from the date of the letter.

TERMINATIONS

Requests to terminate medical coverage should be provided in writing or phone call by the primary insured or agent. Do not stop payment on an EFT draft or close an account in an attempt to cancel a policy. Payors, (other than primary insured) paying the premiums via EFT are not authorized to terminate a policy; however, they are authorized to discontinue premium payments from their account. The policy will automatically be placed on direct bill quarterly.

GRACE PERIODS

- 31-day grace period from premium due date.
- 20-day grace period from the date a bank draft is returned to Assurant Health. Contact the Policyholder Service Desk to redraft the returned premium, or to send in a replacement premium.

DEDUCTIBLE CHANGE REQUIREMENTS

- Changes to the deductible that result in a decrease in premium require a written request or phone call from the primary insured or agent to our Policyholder Service Desk.
- Changes to the deductible that result in an increase in premium require an Application/Enrollment Form and will require full underwriting

POLICY CHANGES/LIMITS/REQUIREMENTS

POLICY CHANGES	LIMITS/REQUIREMENTS
Guaranteed conversion for dependent	60 days from date of removal from parent's/guardian's policy
Guaranteed conversion due to divorce	60 days from date of divorce
Addition of newborn	60 days from date of birth (see InForce Policy Changes in previous section)
Return of guaranteed room benefit option	30 days
Reinstating after military call-up without evidence of insurability	30 days from discharge, or date that extended military coverage ends. (63 days for Illinois)
Return a policy to mark "NOT TAKEN"	10 days from receipt of policy (see Not Taken Policies in previous section)
Terminating with proof of other coverage (backdating a termination date due to other coverage)	30 days limited for backdating. Proof of other coverage must be submitted within 20 days from the date we request proof of other coverage
To stop a termination	Written notice or phone call must be received at Assurant Health before the termination date that was specified. If notice is received after the specified termination date, an Application/Enrollment Form is required.
MD PPO, Changes - Add or Remove	Can be done at any time, however, the effective day must be equal to the issue day of the policy. Request must be received within 30 days of the issue/effective date.
PPO X-tra Rider, PPO Saver, NetSave – Add or Remove	Can be done within 30 days of renewal. The effective date is the policy renewal date. If removed, PPO X-tra cannot be considered for addition again until 12 months later.
Area Change	If an insured moves into a state that offers PPO X-tra from a state that did not offer it, PPO X-tra can be added within 90 days from the date the insured moved.
Changes to the Assurant Clarity℠ Plan	May be restricted if there is an outstanding balance that is due. Once the outstanding balance is paid in full to Assurant Health, the requested policy change can be made.

SIGNATURE/FORM REQUIREMENTS

POLICY CHANGE REQUIREMENTS	FORMS REQUIRED	SIGNATURE
Addition of newborn	Written notification or phone request	Primary Insured (can also be phoned in by Agent)
Any deductible and/or coinsurance change that results in a decreased premium	Written notification or bottom portion of rerate letter or phone call	Primary Insured (adult) or agent
Remove dependent	Written notification or phone request	Primary Insured or agent
Remove spouse	Written notification or phone request	Primary Insured, spouse or agent
Remove primary insured	Written notification or phone request	Primary Insured
Remove benefit riders	Written notification	Primary Insured and/or Insured's over 18 years old
Bank/Account Change/Place on EFT	EFT Authorization Form (contact Policyholder Service Department)	Primary Insured and, if Payor is other than the Insured, the Payor's signature
EFT Authorization	EFT Authorization Form (contact Policyholder Service Department)	Insured and, if Payor is other than the Insured, the Payor's signature
Termination *(See Terminations in the following section)*	Written notification or phone request	Agent/Primary Insured
Mode change	Written notification or phone request	Agent/Primary Insured

SIGNATURE/FORM REQUIREMENTS *CONTINUED*

POLICY CHANGE REQUIREMENTS	FORMS REQUIRED	SIGNATURE
Address change	Written notification or phone request	Agent/Primary Insured
Guaranteed conversion requesting same/ similar benefits	Manually submitted application with the billing section fully completed, signature of eligible conversion applicant if over 18 years of age and only the tobacco question answered.	Primary Insured*
Non-Tobacco User discount	Application/Enrollment Form**	Primary Insured*
Remove Special Class Premium	Application/Enrollment Form**	Primary Insured*
Remove Exclusion Riders/Condition Specific Deductibles	Application/Enrollment Form**	Primary Insured*
Increase room and board	Application/Enrollment Form**	Primary Insured*
Add Maternity and other riders	Application/Enrollment Form**	Primary Insured*
Reinstatements more than 31 days past due (See Reinstatements in following section.)	Application/Enrollment Form**	Primary Insured*
Reinstatements less than 31 days past due (See Reinstatements in following section.)	Submit appropriate premium due; ***or*** call Policyholder Service Desk to redraft EFT account.	Primary Insured
Addition of spouse and/or dependents	Application/Enrollment Form**	Primary Insured and/or Spouse or Dependent if 18 or older
Any deductible and/or coinsurance change that results in an increase in premium due	Application/Enrollment Form**	Primary Insured*
Increasing drug deductible	Written notification or phone request	Primary Insured
Decrease drug deductible*	Application/Enrollment Form**	Primary Insured*
Adding Drug Card	Application/Enrollment Form**	Primary Insured*
Applying for Preferred	Application/Enrollment Form** and Preferred Questionnaire	Primary Insured*

**Additional signatures are required for any dependent 18 years or older, and affected by the change.*

***A signed and dated Underwriting Authorization form is required. Please obtain written authorization from all applicants 18 years or older and retain the form on file should a request for additional medical information be required.*

LAPSES AND TERMINATIONS

LAPSES

Policies on direct bill will receive a combination Lapse/Late Payment Offer when the premium is 10 days past due.

All policies are entitled to a 31-day grace period. The grace period begins the day after the policy due date and ends 31 days after the due date.

REINSTATEMENT

To reinstate a medical policy that has been past due for **less than 31 days**, collection of only one premium on the appropriate premium mode is necessary by mailing or calling the Policyholder Service Desk to have EFT re-drafted.

If the plan is **more than 31 days past due, but less than 6 months since it has lapsed**, then it is necessary to submit a fully completed Application/Enrollment Form to our Inforce Underwriting Department. This form should include complete medical history as indicated on the form along with the type of activity. Inforce Underwriting will fully underwrite to determine eligibility for reinstatement. Normal underwriting guidelines apply. Any change in health history between the date the policy lapsed and the effective date of the reinstatement will not be covered and will be considered during underwriting review.

A reinstated policy will only become effective on or after underwriting approval. Coverage will not be backdated.

Premium should not be submitted with the Application/Enrollment Form, and a Conditional Receipt should not be issued.

What is the difference between a Grace Period and a Late Payment Offer Period? Will there be a lapse in coverage during either period?

There is a 31-day Grace Period offered by the terms of the contract. This means that if a claim comes in during these 31 days, it is considered for payment. Assurant Health also provides a Late Payment Offer Period. This begins on the 10th day after the due date and continues to the 31st day after the due date. No claims will be considered after the 31st day.

TERMINATIONS

Requests to terminate medical coverage should be submitted to the Policyholder Service Desk. Written notification or phone call by the primary insured or agent is required, and a specific date of termination is needed.

NOTE: Except as indicated below, backdating a termination date is not an option.

If a termination request is received through written correspondence and the letter does not indicate a specific termination date, the termination date is determined by the date of the letter. If the letter was not dated, the termination will be the date the letter was received by Assurant Health.

Backdating Termination Dates

Termination due to other coverage or divorce – we will backdate a termination of coverage a maximum of 30 days from the date we were notified, provided that proof of other coverage or divorce decree is received in the Home Office with the request.

Termination due to death or military orders – we will backdate a termination date of coverage with a death certificate or military orders.

Termination due to eligibility rules – it is the responsibility of the insured to notify Assurant Health when a dependent needs to be removed from their policy.

Dependents are considered not eligible when they:

- get married
- are no longer dependent on the parents or legal guardians for support
- reach age 19 through 24, with variations depending on state or policy form number
- are no longer considered disabled

NOTE: An insured dependent will be considered disabled if the dependent cannot engage in any substantial, gainful activity because of his/her physical or mental condition.

A spouse or dependent child who is no longer eligible for coverage, can obtain a similar plan called a Guaranteed Conversion without evidence of insurability if an Application/Enrollment Form is submitted within 60 days after that person's coverage terminates with us.

Refunds

If the termination date is prior to the paid-to date, a premium refund (minus any balance due amount) will be processed.

TeleApp gets your individual medical business processed quickly and simply in three steps:

1. Eligibility Review
2. Completing Part 1
3. Applicant Instructions

The process of these three steps varies by submission methods. The different submission methods are:

- **EASE –** Electronic Agent Sales Experience
- **Fax or mail** Part 1 of the Application

Follow one of two submission methods below to help you proceed through the application process.

EASE – ELECTRONIC AGENT SALES EXPERIENCE

EASE is your Electronic Agent Sales Experience that is a set of online resources which are available on the Agent Sales Web site at assuranthealthsales.com. ***EASE*** makes selling and managing your individual medical insurance products easier than ever before.

EASE expedites your overall sales cycle. With ***EASE***, you'll be able to obtain a quote online and submit your business electronically. You will have access to the most current rates with no software to download.

You'll have the capability to check Underwriting Status online for all policies you sell. All instructions are available online.

If you are interested in learning more about ***EASE***, see your Sales Manager for an informational CD.

Eligibility Review

For ***EASE***, this is done online. This portion of the review is to determine if an applicant meets basic eligibility rules. If a person to be insured answers "Yes" to any of the eligibility questions, the applicant will not be eligible to continue with the application process. If the answers to all of the eligibility questions are "No," the EASE system will allow you to continue to Part 1.

Note: Health care reform updates have not been made to the Eligibility Review section in EASE. If you are submitting an application for family coverage with an applicant under 19 and the system prevents you from submitting electronically due to an eligibility question, please submit a paper application.

Part 1 Completion

For ***EASE***, this is also done online. This consists of basic/demographic applicant information, current insurance information, and billing/payment information. All required information including applicable state forms are completed online. After Part 1 is completed on EASE, the process will continue depending on the applicants resident state: **If you are writing business in an applicant's resident state where Express Underwriting is available, you will have the option of :**

1. Completing the entire medical history and details with your applicant **along with** the applicants email address. Once the medical history and email are completed, the applicant will receive an email directing them to our Online Verification System. This system will allow the applicant to correct and attest that all information they are submitting is accurate. Once they attest to the accuracy, the Online Verification System will submit all information electronically to Assurant Health; **or**
2. Submitting Part 1 of the TeleApp and having the applicant call in for the health interview. This will occur if the agent does not complete the medical review or does not provide the applicant's email address. Applicants must call* to provide their Personal Health History Interview (PHHI) within 10 days of signing Part 1 to ensure the conditional receipt is valid. The agent should then prepare their applicants with instructions. *(See Applicant Instructions section.)*

**Refer to your TeleApp packet for the appropriate phone number.*

If you are writing business in a resident state where Express Underwriting has not yet rolled out:

Submit Part 1 using EASE. Prepare your applicants with instructions (see Applicant Instructions section). Have the applicant call* us with the health interview within 10 days of signing Part 1 to ensure the conditional receipt is valid.

**Refer to your TeleApp packet for the appropriate phone number.*

Applicant Instructions

Applicant instructions should be provided to your customer to prepare them for the Personal Health History Interview (PHHI).

- **Choose one adult person** who is applying for coverage and knows all applicants' health history.
- When a PHHI is completed over the phone, your customer will **speak directly with an Assurant Health Underwriter** (approximately a 15-20 minute interview).
- Your customer should be **ready to review medical history** for everyone who's applying for coverage.
- Have your customer **review the Applicant Instructions and be ready to provide details of medical conditions**, including diagnosis, dates, doctors, treatments, medications and dosages. Only one call should be necessary if properly prepared
- When submitting electronically via EASE, be sure to print all take-away documents to include a copy of the Underwriting Authorization form for all applicants age 18 and over.

Interpreters

We will allow interpreters based on the following guidelines:

- An agent cannot act as an interpreter.
- A spouse, a child age 12 or older or family friend may interpret for the family.
- The interpreter should not answer the questions for the applicant. The applicant should answer with the interpretation following.

PAPER PART 1 SUBMISSIONS *(VIA FAX OR MAIL)*

Paper Part 1 submissions are available for those that do not choose to use ***EASE***, or do not have a computer to submit business electronically. There is a TeleApp packet available for your convenience in completing the application process.

Eligibility Review

Complete the Eligibility Review Form with your Individual Medical customers. This form is contained within the TeleApp packet. Use the Ineligible Medical Conditions, in our Field Underwriting Guide (assuranthealthsales.com), to help you answer the questions.

If a person to be insured answers "Yes" to any of the questions on the Eligibility Review Form, the applicant will not be eligible to continue the application process. You can continue the process with applicants who have answered "No" to any questions, but the outcome of this review is not a guarantee of coverage.

Part 1 Completion

Complete Part 1 with your Individual Medical applicant. This consists of basic/demographic applicant information, current insurance information, and billing/payment information.

- Our billing is easy. Just fill out the simple Billing section. *(See the Billing section for more details.)* If payment is other than EFT or credit card, make sure you mail the payment with Part 1 to ensure the Conditional Receipt is valid. *(See First Premium section for more details.)*
- Have the applicants complete the necessary authorization and forms.
- When applicable, be sure to have your customers sign the Conditional Receipt before you leave it with them.
- Fax* or mail* all pages (except the Conditional Receipt) of the Part 1, the Software Proposal and any applicable state forms and/or authorizations.

**Refer to your TeleApp packet for the appropriate fax number and address.*

Applicant Instructions

Prepare your customer by providing the Applicant Instructions for the Personal Health History Interview.

Note: Though subject to certain state-mandated requirements, **Individual Medical insurance applications are generally valid for 30 calendar days from the date the applicant(s) signed the application**. Once an application expires and is subsequently marked incomplete, a new application (subject to full underwriting) will generally be required in order to consider the applicant(s) for future coverage. While rare, if a business exception is made to reopen a file in which the application previously expired, a current effective date must be accepted.

- **Applicants must call*** to provide their personal health history within 10 days of the Part 1 signature date to ensure the Conditional Receipt is valid.

**Refer to your TeleApp packet for the appropriate phone number.*

- **Choose one adult person** who is applying for coverage and knows all applicants' health history.
- When a PHHI is completed over the phone, your customer will **speak directly with an Assurant Health Underwriter** (approximately a 15-20 minute interview).
- Your customer should be **ready to review medical history** for everyone who's applying for coverage.
- Have your customer **review the Applicant Instructions and be ready to provide details of medical conditions**, including diagnosis, dates, doctors, treatments, medications and dosages. Only one call should be necessary if properly prepared.

Interpreters

We will accept interpreters based on the following guidelines:

- An agent cannot act as an interpreter.
- A spouse, a child age 12 or older or family friend may interpret for the family.
- The interpreter should not answer the questions for the applicant. The applicant should answer with the interpretation following.

You must fully complete the Application/Enrollment Form for the underwriting process to begin. Incomplete applications may not only result in delays, but can also result in the termination of the underwriting process.

Please use black or blue ink when completing the application.

Assurant Health's Application/Enrollment Form for insurance can be used for the following:

- New business
- Guaranteed expiry conversions (divorce or no longer an eligible dependent due to age/student status)
- Internal replacements/upgrades *(See Internal Replacement section.)*
- Changes to existing policies *(See Policy Changes section.)*

An explanation of what is required for each section of the Enrollment form is included in this topic.

Some states require state-specific applications. If a state-specific Application/Enrollment Form is required, it will be indicated on the State Variation form.

You will be sent the appropriate Application/Enrollment Form for your state when you order materials.

NOTE: Forms are available to be downloaded at assuranthealthsales.com.

KEY SECTIONS OF THE APPLICATION/ENROLLMENT FORM

Listed below is an explanation to help you fill out the appropriate information necessary for the underwriting process.

Agent Information

Fill in the Writing Agent's name, Writing Agent number, key contact, fax number, telephone number, e-mail address and Agency name and number. We will contact the agent at these numbers if additional underwriting information is needed.

Type of Activity

Check the appropriate box for a new applicant, or an existing customer who is requesting to replace their policy or make changes to their existing policy. If a customer is upgrading coverage or requesting a change, indicate the existing policy number and check the appropriate box for the requested change.

APPLICATION/ENROLLMENT FORM FOR PAPER NEW BUSINESS

Person(s) to be Insured

Please refer to the *Eligibility Guidelines* in the **Application Guidelines** section before filling in this portion of the Application.

Make sure to fill in the following information:

- Date of birth for all persons to be insured
- Height and weight for all persons to be insured. Check the build tables in the Field Underwriting Guide (assuranthealthsales.com) to determine insurability. If requesting a Preferred Rate, check the height/weight chart or the Preferred Rating Questionnaire.
- Social Security Number for all proposed insureds, including dependents
- Student status for any dependents 18 years of age or older
- Complete resident address (address where you file your state income taxes for those with multiple residences). **P.O. Box is not acceptable.**
- E-mail address
- If any proposed insured lives outside the household address, please explain
- Telephone numbers. We may contact the applicant to verify or get additional information.
- Occupation for the proposed insured and spouse. Check the list of occupations in Field Underwriting Guide (assuranthealthsales.com) to determine eligibility.

Beneficiary for Life Insurance Coverage

If Life Insurance coverage is available to you and you elect it, complete this section.

Other Coverage In Force or Applied For

If this policy is replacing other coverage, we need the name of the other carrier, group or individual coverage, type of coverage, the effective date and the termination date of the other coverage. All questions pertaining to other coverage in force need to be answered.

In addition to this information, we require one of the following in states where continuity of coverage is mandated *(subject to state variations)*:

- The declarations, summary of benefits, or schedule pages; **or**
- A copy of the Certificate of Creditable Coverage.

Some states may require a replacement form, see the Underwriting Guidelines (assuranthealthsales.com).

Hazardous Activities and Driving

These two questions must be answered during the application process.

If an applicant is involved in hazardous activities, refer to the Field Underwriting Guide for more guidelines (assuranthealthsales.com).

BILLING

Complete the Billing section to select the preferred billing type. *(For more details, see Billing section.)*

Health Statement

For expiry conversions only the tobacco question needs to be answered.

All medical questions in the Health Statement section must be answered as they pertain to each applicant. Those questions answered "Yes" require that additional details be included on the Additional Medical Details section of the Application.

If there is not enough room on the Application to disclose the entire history, continue the medical history on a separate piece of paper, and have the proposed insured(s) sign and date it as part of the Application.

It's important to keep in mind that the application asks for diagnosis, treatment and/or consultation with a physician within the past 10 years *(some state variations exist)*. Any continued consultation within the 10-year time period, regardless of the date of onset for a condition, should be disclosed.

Although the question refers to time frame, it is always a good idea to report the complete health history regardless of when incidents occurred.

Requesting the Removal of Special Class Premium,* Special Exception Rider, or Condition Specific Deductible

This section only needs to be completed if an insured is requesting the removal of a special class premium*, condition specific deductible or a special exception rider.

**The removal of special class premium rates are fully underwritten based on customers' full health history.*

Other Physician

If an applicant does not have a regular physician, please provide information about his/her last doctor visit. Indicate the name of the doctor or practitioner, the date the insured was seen, the reason for the visit and the results of the visit.

Additional Medical Details

It is extremely important to give as much detail as possible regarding medical conditions. In our efforts to give you the highest quality service, Assurant Health may conduct a Telephone Verification Report (TVR) with the applicant to obtain additional details and to expedite the underwriting of a particular application. In many cases, the TVR can eliminate the APS (Attending Physician Statement) requirement. In some circumstances, the Underwriting Department may counteroffer a different plan design.

Please provide details to any "Yes" answers given in the Health Statement section of the Application/ Enrollment Form.

NOTE: This information is critical to the underwriting process and can delay decisions if not provided.

The applicant should provide complete details of any treatment that any proposed insured has received, including the following:

- The specific name or diagnosis of the condition, dates of treatment and the type of treatment (including testing done) and results of treatment and condition
- The complete name, address and phone number of the doctor, clinic or hospital that treated the applicant
- The name of any medication prescribed and the dosage
- Status of the condition (e.g., resolved, fully recovered, added follow-ups)

Authorization *(includes the applicant and agents signatures)*

The signature of all proposed insured(s) age 18 and over are required. This includes the signature of the spouse and any dependents over 18 years old. In the case of insurance requested for a minor (under age 18), the signature of a custodial parent or legal guardian is required in lieu of the person to be insured.

The parent or legal guardian must have knowledge of the health of the child. The applicant, if someone other than the custodial parent or legal guardian, must also sign the application.

All attachments to the application, such as additional notes regarding the proposed insured's medical history, should also be signed and dated, and will form part of the application. All attachments will be included in the policy.

The complete date, including the actual time signed, along with the state signed are legal requirements.

Agent Signature

Make sure that the licensed agent properly signs and dates the application. Submit the application immediately. Applications received more than 10 days following the date signed will be subject to the rules for policy dating. If the application is received more than 30 days after the date signed, a new application will be required.

NOTE: See the Licensing Requirements section.

KEYMED[SM] — SPECIFIC GUIDELINES

KeyMed[SM] is no longer available for new business application submission. The information in this section of the guide is provided to support inforce KeyMed policies. The KeyMed plan follows the same guidelines as the standard individual medical portfolio, except for these KeyMed-specific quidelines.

INFORCE POLICY CHANGES

Application Submission

KeyMed applications for inforce policy changes can only be submitted via a paper enrollment form.

UNDERWRITING PRACTICES

Riders

Exclusionary riders and condition-specific deductibles are not available with the KeyMed plan.

Modified Benefit Endorsement (MBE)

In most states, a Modified Benefit Endorsement (MBE) is added to the policy for specific medical conditions. The inpatient hospital and surgical services benefits are paid at 75% of the eligible policy benefit, after a 185-day exclusionary or pre-existing period has been met.

- Requests to have a Modified Benefit Endorsement (MBE) or rating considered for removal may be sent to the Inforce Underwriting Department. The guidelines to have an MBE or rating considered for removal can be found in the KeyMed Underwriting Field Guide (Form 29852).

KeyMed to Another Assurant Health Product

If the health status of an individual covered under a KeyMed plan improves to the point where he/she would be eligible for, and is interested in, an Assurant Health standard individual medical plan, a fully completed application/enrollment form should be submitted using new business submission methods. The new application/enrollment form will be fully underwritten. Pre-existing credit will be given for the period of time the insured was covered under a KeyMed plan.

POLICY CHANGES

KeyMed Plan Changes

There are two plan designs under the KeyMed plan – the $100,000 plan and the $50,000 plan. The plans have set, pre-defined benefits with no additional deductible or coinsurance choices. Therefore, changes to the deductible or coinsurance are not applicable.

After a KeyMed plan has been in force for 12 months or more:

- Requests to change from a $50,000 KeyMed plan to a $100,000 KeyMed plan may be sent to the Inforce Underwriting Department along with a fully completed application/enrollment form. The new application/enrollment form will be fully underwritten. Any change in health history since the initial application will be taken into consideration when assessing the change.
- Requests to change from a $100,000 KeyMed plan to a $50,000 KeyMed plan can be processed with a written request or phone call to the Policyholder Service Desk from either the primary insured or the agent. A new application/enrollment form is not required.

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ASSURANT
Health®

Assurant Health

501 West Michigan

Milwaukee, WI 53203

About Assurant Health

Assurant Health has been in business since 1892 and is the brand name for products underwritten and issued by Time Insurance Company, John Alden Life Insurance Company and Union Security Insurance Company. Together, these three underwriting companies provide health insurance coverage to people nationwide. Each underwriting company is financially responsible for its own insurance products. Primary products include individual medical, small group, short-term and student health insurance products, as well as non-insurance products and consumer-choice products such as Health Savings Accounts and Health Reimbursement Arrangements. Assurant Health is headquartered in Milwaukee, Wisconsin, with operations offices in Minnesota, Idaho and Florida, as well as sales offices across the country. The Assurant Health Web site is assuranthealth.com.

Assurant is a premier provider of specialized insurance products and related services in North America and select worldwide markets. The four key businesses — Assurant Solutions, Assurant Specialty Property, Assurant Health, and Assurant Employee Benefits — partner with clients who are leaders in their industries and have built leadership positions in a number of specialty insurance market segments in the U.S. and select worldwide markets. The Assurant business units provide debt protection administration; credit-related insurance; warranties and service contracts; pre-funded funeral insurance; creditor-placed homeowners insurance; manufactured housing homeowners insurance; individual health and small employer group health insurance; group dental insurance; group disability insurance; and group life insurance.

Assurant, a Fortune 500 company and a member of the S&P 500, is traded on the New York Stock Exchange under the symbol AIZ. Assurant has more than $26 billion in assets and $8 billion in annual revenue. Assurant has approximately 14,500 employees worldwide and is headquartered in New York's financial district. assurant.com.

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