



## Ohio Health Access Plan B or C

*Only a few medical questions to qualify*

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

### **Follow these steps to enroll now!**

- 1. Read the notice on Page 1 of the Rate Sheet regarding multi-plan coverage limitations.**
- 2. Decide who you want to cover** — just you, you and your spouse, just your children, or your entire family. If more than one adult person is applying, choose the youngest adult as the primary applicant.
- 3. Decide which Health Access Plan is right for you** — B or C
- 4. Decide if you want additional options** — you'll find value in:
  - **SuiteSolutions™** — help pay out-of-pocket health related expenses by purchasing an upgraded membership to the basic Health Advocates Alliance membership.
  - **Cancer Benefit** — customize your coverage by adding the \$25,000 Cancer Benefit for outpatient services to treat malignant cancer.
  - **Dental-Vision Discount Plan** — this is a discount plan (not insurance) for your entire family.
- 5. Calculate your total premium** — transfer the monthly rate / fee from the prior selections to the calculation table to determine your total monthly premium.
- 6. Start the application process for Plan B or C.**
- 7. For quick approval, fully complete the enrollment form with your agent, including:**
  - All required questions
  - Requested effective date
  - Signatures — which are required for all applicants age 18 and older (child-only policies need a parent or guardian signature)

Agent: Leave this sheet with your client



Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth \_\_\_\_\_ State of Residence \_\_\_\_\_

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

Circle the monthly rate of the coverage that applies.<sup>a</sup>

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

<b>HEALTH ACCESS PLAN B MONTHLY RATES</b>					
AGE	0-17	18-30	31-40	41-50	51-63
Primary	\$51.00	\$83.00	\$97.00	\$128.00	\$196.00
Primary and spouse	\$102.00	\$166.00	\$194.00	\$256.00	\$392.00
Primary with 1 child	\$102.00	\$134.00	\$148.00	\$179.00	\$247.00
Primary with 2 or more children	\$173.40	\$205.40	\$219.40	\$250.40	\$318.40
Primary and spouse with 1 child	\$153.00	\$217.00	\$245.00	\$307.00	\$443.00
Primary and spouse with 2 or more children	\$232.05	\$296.05	\$324.04	\$386.05	\$522.05

<b>HEALTH ACCESS PLAN C MONTHLY RATES</b>					
AGE	0-17	18-30	31-40	41-50	51-63
Primary	\$65.00	\$104.00	\$118.00	\$154.00	\$234.00
Primary and spouse	\$130.00	\$208.00	\$236.00	\$308.00	\$468.00
Primary with 1 child	\$130.00	\$169.00	\$183.00	\$219.00	\$299.00
Primary with 2 or more children	\$221.00	\$260.00	\$274.00	\$310.00	\$390.00
Primary and spouse with 1 child	\$195.00	\$273.00	\$301.00	\$373.00	\$533.00
Primary and spouse with 2 or more children	\$295.75	\$373.75	\$401.75	\$473.75	\$633.75

This membership is required; see footnote\*.

<b>HEALTH ADVOCATES ALLIANCE (HAA) MEMBERSHIP* - REQUIRED</b>	
Membership in HAA is required and provides additional benefits and discounts for a variety of services - for members only.	<b>\$4.00 per month</b>

See Page 3 for additional options and to calculate your premium

This Rate Sheet is for use with product brochures and state variations which contain details of Assurant Affordable Health Access Plans and the optional benefits. The rates for this limited-benefit plan are only valid for plans issued with effective dates from September 1, 2009, and later. Rates quoted more than 30 days in advance of the requested effective date are subject to change and are not guaranteed. Issuance of coverage is subject to approval. This proposal is not an insurance contract. Only the actual contract provisions apply. The effective date of the quote does not guarantee coverage and is subject to change. Rates are based on primary's age as of the effective date of the plan. Final rates may vary. All rates are subject to underwriting approval.

\*Membership in Health Advocates Alliance is required to obtain the opportunity to access this health insurance coverage. Fees paid for membership in Health Advocates Alliance are used for benefits, marketing, distribution and administrative expenses. Assurant Health may also realize some benefit from these fees.

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company.

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Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth \_\_\_\_\_ State of Residence \_\_\_\_\_

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

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

**SuiteSolutions<sup>®\*\*</sup> - Upgrade your HAA membership with one of these membership levels that can protect you financially from medical bills associated with sudden, serious medical needs**

SecureSolution Accident Medical Expense Benefit Level	Monthly Fee to Upgrade HAA Membership		SelectSolution Accident Medical Expense and Critical Illness Expense Benefit Level	Monthly Fee to Upgrade HAA Membership	
	Single	Family		Single	Family
\$2,500	\$29.95	\$39.95	\$2,500	\$45.95	\$55.95
\$5,000	\$33.95	\$43.95	\$5,000	\$49.95	\$59.95
\$10,000	\$38.95	\$53.95	\$10,000	\$59.95	\$69.95

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

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

Signature (required) \_\_\_\_\_

Date Signed \_\_\_\_\_

Add these optional benefits to customize your coverage by circling the rate. **NOTE: The selection of your family composition must be the same as your selection for the Health Access Plan.**

**CANCER BENEFIT - Additional benefits for outpatient services to treat malignant cancer**

AGE	0-17	18-30	31-40	41-50	51-63
Primary	\$20.27	\$27.39	\$46.02	\$96.80	\$146.86
Primary and spouse	\$40.54	\$54.78	\$92.04	\$193.60	\$293.72
Primary with 1 child	\$40.54	\$47.66	\$66.29	\$117.07	\$167.13
Primary with 2 or more children	\$68.92	\$75.63	\$94.26	\$145.04	\$195.10
Primary and spouse with 1 child	\$60.81	\$75.05	\$112.31	\$213.87	\$313.99
Primary and spouse with 2 or more children	\$92.23	\$106.47	\$143.73	\$245.29	\$345.41

**DENTAL-VISION DISCOUNT PLAN**

The Dental-Vision Discount Plan covers everyone in your household. The Dental-Vision Discount Plan is a discount program and is not insurance. \$9.95 per month

**3. Calculate your total premium**

BENEFITS	MONTHLY RATE/FEE
Health Access Plan B or C Monthly Rate	
Health Advocates Alliance (HAA) Membership Fee	+ \$4.00
SuiteSolutions Upgraded HAA Membership Fee	+
Cancer Benefit	+
Dental-Vision Discount Plan	+
<b>TOTAL MONTHLY PREMIUM</b>	<b>=</b>

This Rate Sheet is for use with product brochures and state variations which contain details of Assurant Affordable Health Access Plans and the optional benefits.

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

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# Health Access Plan B or C Enrollment form for limited benefit health insurance

PLEASE PRINT IN BLACK INK

## PERSON(S) TO BE INSURED

Attach a separate sheet, signed and dated, if additional space is needed below.  
Label additional dependents starting with the letter "E" and after.

Only complete the spouse and dependent information if it applies.

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

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

5. Phone Number: (\_\_\_\_\_) \_\_\_\_\_

6. E-mail Address: \_\_\_\_\_

7a. Work Number: (\_\_\_\_\_) \_\_\_\_\_

7b. Are any of the proposed insureds covered by, or has application been made for any type of medical insurance? .....  Yes  No  
If "Yes," complete the section below.

Examples of types of coverage are individual medical insurance, group insurance, and supplemental coverage for specific conditions, like cancer.

Proposed Insured's Name	Insurance Company Name	Group or Individual	Type of Coverage	Effective Date (MM/DD/YY)	Termination Date (MM/DD/YY)	Is this coverage being replaced by proposed coverage?

## REQUESTED EFFECTIVE DATE

8. Requested effective date \_\_\_\_\_

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

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

**HEALTH STATEMENT**

To determine if you're eligible for this individual medical plan, you need to answer a few medical questions for you and anyone else applying for coverage.

*Attach a separate sheet if additional information is needed.  
Date and sign any additional sheets.*

**Note: The plan cannot be issued to any person who answers YES to any of the following questions.**

Enter dependent information in same order as page 1.

		Primary	Spouse	A:	B:	C:	D:
9. Are you, your spouse, or any person to be insured now pregnant, an expectant parent, in the process of adopting a child or undergoing infertility treatment?	Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. For any of the following conditions within the last 5 years, have you or any person to be insured received any abnormal test results or medical or surgical treatment, or consulted a health care professional, or taken medication for:	Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> <li>• Heart disorder, excluding Mitral Valve Prolapse (MVP) or surgically corrected or closed Atrial Septal Defect (ASD)/ Ventricular Septal Defect (VSD)</li> <li>• Stroke</li> <li>• Crohn's Disease or Ulcerative Colitis</li> <li>• Liver disorders, excluding fully recovered Hepatitis A</li> <li>• Kidney disorders, excluding kidney stones</li> <li>• Emphysema or Chronic Obstructive Pulmonary Disease (COPD)</li> </ul>	<ul style="list-style-type: none"> <li>• Diabetes, excluding Gestational Diabetes</li> <li>• Basal Cell Carcinoma with recommended surgery that has not been completed</li> <li>• Cancer or Tumor</li> <li>• Alcoholism, Alcohol or Chemical Dependency, or Drug or Alcohol Abuse</li> <li>• Multiple Sclerosis (MS)</li> <li>• Tuberculosis (TB)</li> <li>• Any condition that resulted in Bariatric Surgery</li> </ul>						
11. Have you, your spouse, or any person to be insured in the last 5 years tested positive for, or received surgical or medical treatment, or taken medication for the Human Immunodeficiency Virus (HIV) infection or been diagnosed as having, or received surgical or medical treatment, or taken medication for AIDS-related complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS)? For purposes of answering this question, you do not need to respond in regard to an initial positive test result that later testing proved false.	Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## BILLING

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

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

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

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

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

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

You have four billing methods to choose from:

### 1. Monthly payroll deduction (list bill)

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

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

- To begin withdrawals:  
Select a desired withdrawal date 1-28: \_\_\_\_\_  
Bank name: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_  
Routing number: \_\_\_\_\_  
Account number: \_\_\_\_\_

Jane Doe  
1234 Any Street  
Anytown, US 12345

DATE \_\_\_\_\_

PAY TO THE ORDER OF \_\_\_\_\_ \$ \_\_\_\_\_ DOLLARS

ANYTOWN BANK

MEMO \_\_\_\_\_

123456789 0987654321 1234

Routing Number Account Number  
9 digits

- To add this policy to an existing EFT

Existing EFT number \_\_\_\_\_  
Associated policy number: \_\_\_\_\_

### Authorization for EFT – please sign below

I (we) hereby authorize Time Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, indicated on the other side, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Accountholder signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

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

Choose method:  Monthly EFT  Bill me directly

### Authorization for credit card payments – please sign below

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

Card number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Card type:  MasterCard  VISA

Expiration date: \_\_\_\_/\_\_\_\_

Name as it appears on card: \_\_\_\_\_

Address of cardholder, if different: \_\_\_\_\_

Cardholder signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

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

Billing Address: \_\_\_\_\_  
(Street) (City) (State) (ZIP)

Name of person paying, if different: \_\_\_\_\_

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

**LIFE INSURANCE**

Complete this section to designate a beneficiary for life insurance.

Beneficiary for Primary Insured: \_\_\_\_\_  
(Full Name) (Relationship)

Contingent Beneficiary: \_\_\_\_\_  
(Full Name) (Relationship)

**HEALTH ADVOCATES ALLIANCE MEMBERSHIP APPLICATION**

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

Health Advocates Alliance is a membership organization that promotes good health among its members and their communities. Membership in the Alliance is required in order to be eligible for health insurance coverage. Membership privileges include the opportunity to participate in programs offered or sponsored by the Association. Among the programs offered, is the opportunity to apply for health insurance. For additional information and benefits provided by the Association please see the Health Advocates Alliance Brochure (Form JI-1033).

I hereby request enrollment in the Health Advocates Alliance. I understand that nominal dues are required for membership in the Association; if participating in a sponsored insurance program, then my annual dues may be collected in installments along with my insurance premiums. I also understand that membership dues are non-refundable, and my failure to remit membership dues will result in loss of eligibility to participate in any of the Association sponsored programs or benefits.

Member Signature

Date

**HIPAA ELIGIBILITY**

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

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), certain individuals have a guaranteed right to an individual plan without a pre-existing exclusion. In order for Time Insurance Company to determine whether you or anyone applying for coverage is entitled to such a plan, please review the following and indicate whether ALL of the below statements are true at the time you or anyone to be insured applies for individual coverage:

- You have at least 18 months of continuous creditable coverage without any break in coverage greater than 63 days.
- Your most recent coverage was under a group plan, a governmental plan or a church plan.
- You are not covered under another group health plan.
- Your most recent coverage was not cancelled because you did not pay premiums or because you committed fraud.
- You are not currently eligible for Medicare or Medicaid.
- You have exhausted any continuation of coverage (COBRA or state continuation) for which you were eligible.

No, I or anyone to be insured do not meet any of the above requirements.

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

**EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT**

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

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

Do you agree with this statement? .....  Yes  No

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

## AUTHORIZATION

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

I understand the insurance coverage is subject to underwriting. The insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company. The effective date is assigned by Time Insurance Company. The first full premium must be paid. A change in the health of the proposed insured(s) after the completion of the enrollment form and before the delivery of the contract may affect my eligibility for insurance with the company. I understand and agree that any information I provide through this application process may be shared with persons necessary to facilitate issuing coverage, including but not limited to my agent or broker.

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

In order to determine my (our) eligibility for insurance, I hereby authorize any health care provider or medically related facility, pharmacy, pharmacy benefit manager or pharmacy related facility, MIB, Inc., ("MIB") formerly known as the Medical Information Bureau, consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information including information regarding employment, other insurance coverage, personal information, medical or pharmacy care, advice, treatment, or medication use as may be requested to Time Insurance Company (or any consumer-reporting agency authorized by Time Insurance Company), its legal representative or any medical records retrieval service Time Insurance Company may engage, including, but not limited to, EMSI, Examination Management Services, Inc. and its agents.

This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs. This information may also be disclosed to the Medical Information Bureau, Inc. and any medical records company engaged by Time Insurance Company, including but not limited to EMSI and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations.

I understand that this authorization is required in order to enable Time Insurance Company to make eligibility or enrollment determinations relating to me and/or my minor children or for Time Insurance Company's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for enrollment.

I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, P.O. Box 3050, Milwaukee, WI 53201-3050. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.

Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: 30 days after denial of my application, or declination of enrollment, or, if insured, 30 days after when I am no longer an insured of Time Insurance Company. But in no event will this authorization be in effect for longer than 30 months from the date signed.

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

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

I acknowledge that I have read the completed enrollment form. I attest that all statements and answers on this enrollment form are complete, true and correct. I understand and acknowledge that any statement, material misrepresentation or omission on the enrollment form, recorded Authorizations, recorded personal health history and/or any amendments which are willfully false or fraudulently made may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provisions of the contract.

I understand that the coverage offered provides LIMITED BENEFITS and has specific benefit limitations.

\_\_\_\_\_  
Signature of Primary Proposed Insured

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

\_\_\_\_\_  
Signature(s) of Other Dependent(s) 18 or Over  
(if proposed to be insured)

\_\_\_\_\_  
Guardian's Signature

Premium Amount Sent: \$ \_\_\_\_\_

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

\_\_\_\_\_  
City and State signed in

Attention: (Agent)

I have reviewed this enrollment form to ensure that all required items have been completed.

To the best of my knowledge, there  
 IS  IS NOT  
a replacement of medical insurance  
involved in this transaction.

\_\_\_\_\_  
Licensed Resident Agent's Signature

\_\_\_\_\_  
Print Agent's Name

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

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**ARE YOU AN EXISTING CUSTOMER?**

Policy # \_\_\_\_\_

What do you want to do?

- Add Dependent
- Policy/Benefit Change to an existing policy  
*List type of change requested:* \_\_\_\_\_
- Reinstatement of Coverage
- Internal Replacement
- Conversion (over-age dependent/divorce)

**AGENT/AGENCY INFORMATION**

Agent Name: \_\_\_\_\_

Agent Number: \_\_\_\_\_

Key Agency Contact: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Agency Name: \_\_\_\_\_

Agency Number: \_\_\_\_\_

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

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

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

## **IMPORTANT NOTICES – LEAVE WITH CUSTOMER**

### **NOTIFICATION REGARDING (“MIB”) formerly known as the MEDICAL INFORMATION BUREAU**

Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of information in MIB’s file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB’s information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734.

Time Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life, or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

### **ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES**

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.

### **FRAUD NOTICE**

It is unlawful to knowingly provide willfully false, incomplete, misleading or fraudulently made facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides willfully false, incomplete, misleading or fraudulently made facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.

### **PRIVACY**

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on enrollment forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.

**LEAVE THIS PAGE WITH THE CUSTOMER - DO NOT FAX**