

CRL

Association/Individual Producer Guide



Introduction

This guide contains **general information** regarding Central Reserve Life's (CRL) administrative and product descriptions and is not state specific. This guide should be used in conjunction with the underwriting guidelines.

Due to the constant changes in federal and state mandates on health insurance, it is important for you to keep current on laws enacted within your state and on a federal level that affect the life and health insurance industry.

Please remember that no agent has the authority to change any benefits, to bind coverage with CRL or to promise a certain effective date. No statement made by any representative of CRL shall be binding on CRL if in conflict with the provisions of the policy. Nothing in this guide will waive or alter any of the terms and conditions of the policy; and if any discrepancies, misprints or changes of benefit occur, the policy will govern.

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Agent Licensing

- The agent must be licensed and appointed with the company in the state where the insured/applicant resides.
- New business cannot be solicited in the following states until the agent holds an active appointment and has been notified by the Licensing Department of appointment approval: Delaware.

In all other states, the agent must hold an active license and submit the licensing/contracting papers simultaneous with the new business submission. However, we encourage agents to be licensed and trained with us prior to soliciting business.

General Plan Eligibility

- Must be a member of the Eagle Consumer Association (ECA).
- Minimum age is 16 and maximum age is 64.5—requirement to be a member of ECA.
- An application should not be submitted if the proposed insured has made plans to live outside the United States, does not have permanent U.S. residency status or is not a U.S. citizen.
- If the applicant is a student, we must clarify the physical address of where he/she is attending school.
 - a. If the individual is going to school in a state where CRL is not soliciting or licensed, the application will be denied.
 - b. If the individual is attending school in an acceptable state, the rates will be based on where the individual is attending school.
 - c. In the event that the bill is sent to the parent's house, the Alternate Billing Address will be utilized. All correspondence will generate to the student, except for the premium billing.
- **CRL Individual and Association Group Major Medical Ineligible Occupation List: (Subject to state mandates.)**
 - Actors, Actresses, Entertainers, Escort Services, Strippers, Models and Stunt Men
 - Asbestos and Toxic Chemical Workers
 - Athletes (professional)
 - Attorneys
 - Aviation (high-risk - experimental or test pilots, aerial photographers, etc.) and Crop Dusters
 - Bar and Tavern Owners and Bartenders
 - Billiard Halls
 - Circus and Carnival Workers
 - Correctional Institute Employees
 - Deep Sea Divers
 - Demolition, Explosive and Wrecking Workers
 - Dock Workers (longshoremen and stevedores)
 - Drivers (mining, racing and testing)
 - Fishing Industry (commercial, not returning to port each night)
 - Halfway House Workers for Alcohol or Drug Rehabilitation
 - Jockeys or Horse Trainers
 - Logging and Mill Workers (to include tree trimmers)

- Massage Parlors
 - Meat Packing & Slaughterhouse Workers (Live Animals)
 - Migrant Workers
 - Mining, Quarry and Foundry Workers
 - Musicians (except full-time concert and symphony performers)
 - Oil Rig, Oil & Natural Gas Workers and On or Off-Shore Drillers
 - Physicians
 - Pyrotechnists
 - Rodeo Participants
 - Structural Steel and Iron Workers and Steeple Jacks
 - Tattoo Artist/Tattoo Parlor Owners
 - Tunnel and Caisson Workers
- *For MSA's Qualified Plans*, the applicant must be self-employed and not covered under any other major medical plan. (American Health Value is our endorsed MSA fund vendor. Contact them at 800-914-3248.)

Eligible Dependents:

- Spouse (if not legally separated from the applicant).
- Unmarried child until the date the child attains age 19 including: (1) a legally adopted child or a child placed for adoption; or (2) a stepchild who permanently resides with the applicant.
- Unmarried child age 19 or over who is incapable of earning a living due to mental retardation or physical handicap. (CRL must be provided with proof of incapacity.)
- Unmarried child 19 but under 23 years of age enrolled as a full-time student in an accredited school and is financially supported by the applicant. Age requirements may vary by state.

Quoting Software

You may download the quoting software from the Agent's Secure Site. In order to download the quoting software, go to www.centralreserve.com.

- Click on **"Agents"**. For the first time entering the Agent's Secure Site, use your social security number as the User ID and Password. You will be required to enter specific information as well as change your password. Once all information is entered, click on "Submit." You will now be at the Agent Secure Site.
- Click on **"Association/Individual Software"** to download current rate information on the CRL Simplicity Plus Plans. Simply follow the download instructions.

Your MGA/GA should notify you when there is an update to the quoting software.

Information You Should Know Before Submitting a Case

Websites:

- www.centralreserve.com. For comprehensive information, please visit our website at www.centralreserve.com. Select the "Agent" option. Hit submit (don't enter anything). Then enter your username and password; use your social security number in both fields. Hit OK.
- www.ceres.pponet.com. Select the "CRL" option to locate in-network hospital and medical providers or dental providers. For First Health Network providers, go to the First Health button.

Preferred Providers:

When your client visits providers in the PPO network shown on their ID card, they are protected from being billed for amounts above the reasonable and customary charge limits of their insurance. Since the PPO providers have agreed to negotiated charges, there will be no balance billing. We also apply PPO discounts before the deductible and coinsurance amounts are calculated, which can mean significant savings for them!

If individuals are obtaining healthcare service from providers who are not in their network, they will incur a greater out of pocket expense.

A PPO program offers freedom and flexibility.

- Choose between all participating providers in a PPO network in order to receive in-network discount rates,
- Select providers who are either in-or out-of-network,
- Visit specialists without referrals.

Non-Network Negotiation and Exception Services (Part of the Care Coordination Benefit-See brochure for complete details).

If a PPO provider is not available within a reasonable distance from the insured's home, or if there is no provider within our network who performs the required service, your insured can call **1-877-575-4207** or e-mail nonnet-exempt@ceresgp.com for assistance. We will help locate a non-network provider and attempt to negotiate the cost to help save them money. Our goal is to eliminate or reduce any balance billing to our insured.

In order to provide our customers with the best service possible, when we receive requests for non-network exceptions we relay this information to our PPO networks. This information helps networks determine where they may want to add new providers to their network.

Provider Locator Service – Use a wide range of medical providers while saving insureds money.

To locate in-network providers, please visit our website at www.centralreserve.com and go to **Provider Locator** OR www.ceres.pponet.com. Insureds can also consult their directory* or call us toll-free at 1-877-575-4207 (available 24 hours a day, 7 days a week).

To nominate a provider to a network, individuals should complete a Provider Nomination form. These forms are included in their customized provider directory and are also available from agents.

* Information is only as current as the networks have provided and we cannot guarantee that at the time of printing for each insured, all providers' information is accurate. Advise insureds to check with their provider at each time of service that they are still contracted with the network shown on the insured's ID card.

Pharmacy Benefits

The plan may include a three-tier pharmacy benefit:

Generic—always the most affordable option,

Brand Name Formulary*—offering increased savings over brand name medications not on the Formulary, and

Brand Name Non-Formulary*—insured will share a larger part of the cost of the brand name medication.

* Formulary—a list of carefully selected medications that can assist in maintaining quality care, while helping to lower the cost of prescription drugs.

Our pharmacy provider, Express Scripts, located at www.express-scripts.com, has a program that includes:

- 24 hour, 365-day/year access to the Express Scripts Customer Service Call Center at **1-800-287-4526**.
- A national network of over 53,000 pharmacies.
- A personalized list of local pharmacies based on zip code.
- A nationwide pharmacy locator available by contacting the Express Scripts Customer Service Call Center at **1-800-287-4526** or on the CRL agent website under **Pharmacy Locator**.
- Convenient home delivery of medications through the mail order service program. (May not be available for all benefit plans.)

Express Scripts also offers a personalized pharmacy website that has services designed for individuals. The site provides complete pharmacy information, including benefits plans and coverage, drug costs, drug comparisons and an online mail order service pharmacy—so individuals can save money and much more!

Personalized services include:

- Benefit Plan—a detailed description of an individual's plan and coverage, including pharmacies in his or her network, and a formulary list.
- Prescription History—an individual's personal record of his or her prescription history.
- Online Mail Order Service Pharmacy—individuals can save money by ordering prescriptions online through Express Scripts.
- Drug Information—get answers to specific questions about medications, including drug interactions, drug comparisons and more.

For an insured to register, simply visit <http://member.express-scripts.com> and follow the simple instructions provided.

LabOne

The LabOne's Lab Card Program and LabOne Select Programs are offered* as voluntary, member-driven cost containment programs designed to compliment the health plan, yet not replace the lab benefits under the plan.

If an insured has a deductible of \$1,000 or less they have the LabOne's Lab Card Program available to them. This program provides outpatient lab services and specimens for covered services at no charge to the insured. The insured pays no deductible, no copayment and no coinsurance for lab services when using LabOne.

If an insured has a deductible greater than \$1,000 they have the LabOne Select Program available to them. This program provides outpatient lab services and specimens for covered services at reduced costs. The services will be subject to the lab benefit under the health plan, but out-of-pocket expenses will be reduced when using LabOne.

All an insured needs to do to take advantage of the LabOne programs is simply show his or her LabOne card to the doctor and request that lab work or specimens be sent to LabOne for processing. The doctor customarily collects the specimens and calls LabOne for pickup. If a doctor is unable to collect the specimen, LabOne has contracted draw sites available.

LabOne provides a LabOne card and other materials that provide instructions to the provider on how to send lab work or specimens to LabOne or on how to locate a draw site. LabOne will submit claims for services directly to CRL.

* The LabOne programs are not available to insureds in the MAMCO/Berkshire Health Network.

Case Submission

- Refer to Checklist for Submission of Association/Individual Business on page ten for all appropriate forms.
- Verify applicant's identity by reviewing driver's license, state I.D. or passport
- Payroll deduction or list bill is available in some states; refer to the checklist on page ten or contact your GA/MGA for further details.
- Application must be completed in full by the applicant (see pages 12-14 for important highlights of this form). Applications must be completed in black or blue ink.
- All insurance applications must be signed and dated the actual date that they are completed.
- If a signature appears altered, the application will be returned to obtain a new completed enrollment application.
- Applications are valid for 90 days.
- Applications received without a payment will not be processed.
- If spouse is applying for coverage, spouse's signature must be completed and indicates complete disclosure of information.

- If a dependent age 18 or older is applying for coverage, the dependent's signature is required.
- Non-custodial parents—when a child considered for coverage does not live with the applicant, we require the signature of the parent/guardian with whom the child lives.
- Agents are required to submit all cases through their GA/MGA office. The GA/MGA will then submit the case to the Home Office.
- CRL's Home Office must receive all insurance applications within 21 days from the completion date.
- Once the case is submitted, the final rates are determined by the underwriter. You will be notified by your MGA/GA of the final offer.
- The COAST system can be accessed for inquiry on application status through the CRL website under **AGENT**.
- All communications should be directed to the GA/MGA office.
- Care Coordination Fee – consult the 24-Hour Care Coordination Services information in the brochure.
- A network must be chosen at time of application. It must be listed on the application and quote. This is a requirement of issue.
- Review Underwriting Guidelines (MAN-GPT30) for details on many conditions and ailments to determine if an application should be submitted or what the underwriting outcome may be.
- The agent has no authority to change benefits or bind coverage.
- If the insurance applied for is withdrawn, CRL's only obligation will be to refund the amount paid for insurance premium.
- If First Health, MMO, Arizona Foundation or Horizon Health Networks are selected, the applicant may apply for plans with a 90% in-network coinsurance.

Effective Dates:

- If coverage is approved, CRL will determine the actual effective date of coverage, which may differ from the applicant's requested effective date.
- No insurance coverage is in effect until a written notice of approval and the actual effective date is received by the applicant from the Home Office.
- The effective date will be the 1st of the month following underwriting approval. We will allow the 15th of the month on a request basis. (Note: monthly premiums will always be from the first of the month; we would prorate the first premium billing statement for a 15th of the month effective date.
- The USR will reflect the possible effective date taking into consideration the outstanding information the underwriter is requesting. We will not backdate an effective date more than five days beyond the date the application is approved for coverage.

Mandates:

Due to constant changes in federal and state mandates on health insurance, it is important that you keep current on the laws enacted within your state and on a federal level that affects your area. These guidelines may change to comply with state requirements. This plan is not being sold or administered as an employee benefit plan, and the Member’s employer is not responsible, either directly or indirectly, for paying the premium or benefits. Since this plan is not an employer plan, any small employer laws do not apply.

Height & Weight Chart

FEMALE						
Height	Accept	10 Debits	20 Debits	50 Debits	80 Debits	Decline
4'8"	81-143	144-155	156-166	167-178	179-190	191+
4'9"	84-146	147-160	161-171	172-184	185-195	196+
4'10"	87-152	153-164	165-175	176-191	192-200	201+
4'11"	90-156	157-167	168-178	179-197	198-205	206+
5'0"	93-161	162-171	172-183	184-202	203-210	211+
5'1"	96-166	167-176	177-188	189-207	208-215	216+
5'2"	99-171	172-180	181-192	193-212	213-220	221+
5'3"	102-177	178-186	187-199	200-217	218-225	226+
5'4"	106-182	183-190	191-203	204-224	225-232	233+
5'5"	108-188	189-195	196-209	210-231	232-239	240+
5'6"	110-191	192-199	200-216	217-239	240-247	248+
5'7"	114-197	198-205	206-223	224-246	247-254	255+
5'8"	117-202	203-211	212-229	230-254	255-262	263+
5'9"	121-209	210-218	219-236	237-262	263-270	271+
5'10"	123-214	215-222	223-243	244-270	271-278	279+
5'11"	128-222	223-231	232-250	251-261	282-286	287+
6'0"	132-228	229-238	239-257	258-286	287-294	295+
6'1"	136-225	226-244	245-264	265-294	295-302	303+
6'2"	138-240	241-250	251-271	272-302	303-310	311+
6'3"	141-246	247-256	257-289	290-311	312-319	320+
6'4"	146-253	254-263	264-286	287-319	320-327	328+

MALE						
Height	Accept	10 Debits	20 Debits	50 Debits	80 Debits	Decline
5'0"	96-162	163-174	175-186	187-202	203-210	211+
5'1"	99-168	169-180	181-192	193-208	209-216	217+
5'2"	102-173	174-187	188-199	200-217	218-225	226+
5'3"	105-179	180-193	194-206	207-227	228-235	236+
5'4"	109-185	186-199	200-212	213-232	233-240	241+
5'5"	112-190	191-204	205-218	219-242	243-250	251+
5'6"	115-196	197-211	212-225	226-247	248-255	256+
5'7"	119-202	203-217	218-231	232-253	254-261	262+
5'8"	123-208	209-223	224-238	239-262	263-270	271+
5'9"	126-214	215-230	231-246	247-272	273-280	281+
5'10"	130-221	222-236	237-251	252-282	283-290	291+
5'11"	133-226	227-242	243-259	260-287	288-295	296+
6'0"	137-233	234-249	250-266	267-293	294-301	302+
6'1"	141-240	241-257	258-275	276-302	303-310	311+
6'2"	145-246	247-264	265-282	283-312	313-320	321+
6'3"	149-253	254-272	273-290	291-322	323-330	331+
6'4"	153-260	261-279	280-298	299-332	333-340	341+
6'5"	157-267	268-286	287-305	306-342	343-350	351+
6'6"	161-274	275-294	295-314	315-352	353-360	361+
6'7"	165-281	282-302	303-322	323-362	363-370	371+
6'8"	169-288	289-309	310-330	331-372	373-380	381+

Underwriting Process

Verification: Upon receipt of the enrollment materials at CRL, each application is acknowledged with a verification telephone call to the applicant or spouse (if spouse has applied for coverage and has signed the application). Verification is part of the underwriting process. The verification call confirms the accuracy and validity of the completed application. It is very important that the agent explains and supports the verification process.

The phone call is recorded and is considered part of the application, which becomes part of our permanent record. The information obtained through verification is confidential and will not be released without the written consent of the applicant. The call will be tape-recorded and will take approximately ten (10) minutes. Verifying complete information at the time of application will reduce investigation at claims time—improving service for you and your clients.

The enrollment application cannot be considered if the verification call is not complete.

As indicated on the application, the applicant during verification call must disclose any health condition for his/her self or any of their dependents that has changed from the date of the application.

The applicant indicates on their enrollment application convenient times they can be contacted for the verification call. Calls are made Monday through Thursday between the hours of 8:00 a.m. and 7:00 p.m. (EST) or Friday between the hours of 8:00 a.m. and 3:30 p.m. (EST). If the applicant cannot provide a specific time they can be contacted by the Verification Department, they may contact the Verification Department by calling 1-800-253-4651 Monday through Thursday during the following hours: 8:00 a.m. to 7:00 p.m. (EST) or Friday between the hours of 8:00 a.m. and 3:30 p.m. (EST).

Underwriting Case Status:

Initial status requesting additional details will be sent to the General Agent/Managing General Agent or will be available on COAST.

Pending:

- CRL will place a file into a pending status for up to 45 calendar days from the date of receipt at the Home Office.
- If a complete response to the Underwriting Status Report (USR) is not received within this 45-day period, the file will be closed for insufficient information. The USR will reflect this so you are aware of the time period.
- If **all** of the USR requirements are received after the file is closed, but no more than 60 days from the application completion date, the file will be reopened and the underwriter will notify accordingly.
- If all requirements are received more than 60 days from the application completion date but less than 90 days, it will be at the Underwriter’s discretion to determine the requirements to process the application. If the underwriter determines to reopen

the case, a signed statement from the applicant will be required certifying that the health status of the applicant and dependent(s) has not changed since the date of the original application for insurance with CRL.

Exclusion Riders:

Exclusion riders may be used to exclude a specific medical condition, hazardous avocations or to exclude a dependent with an unacceptable medical condition. If a rider is required, the rider must be signed and dated by the applicant prior to approval of the case.

Denials:

If we are unable to offer coverage, whether due to medical, eligibility or insufficient information, a letter will be sent to the member, to the agent and to the GA/MGA. If a file is closed for insufficient information or is withdrawn, it will be at the underwriter's discretion to determine if new enrollment materials are required to reopen the file once the information is received.

In the event of a declination, the initial premium, administrative fees, association dues and application fee will be refunded to the applicant. The applicant should not terminate prior coverage until written notice of approval is received.

Rescission:

A contractual remedy allowed to insurance companies when there has been **material non-disclosure** on the part of the applicant. A rescission puts all parties back in the same position they would have had if the health history had been disclosed on the application and coverage not issued. Premium payment is returned to the former insured, less any claims paid, and the agent is charged back for any commissions paid. Rescission action is taken within the policy or certificate contestable period.

Underwriting for the Critical Payment Benefit Rider*

All applicants must be between the ages of 18 and 64½. No one with a prior history of internal cancer, leukemia, AIDS, ARC, heart attack diabetes, stroke, kidney disease, Alzheimer's Disease, Multiple Sclerosis, Epilepsy, paralysis, or use of illegal drugs will be issued coverage. Underwriting will also review other significant medical history for specific conditions such as heart disease or disorders and any other condition related to the coverage being provided.

In addition, no more than three immediate family members of the applicant may have been diagnosed, before the age of 55, with heart disease, a heart attack, stroke, kidney disease, insulin dependent diabetes, internal cancer, leukemia, or Hodgkin's Disease. An immediate family member of a insured person is a father, mother, brother or sister related by blood.

The Critical Payment Benefit Rider will either be issued or declined. There will not be exclusionary riders issued. The Critical Payment Benefit Rider may be declined and the medical coverage may be issued. All applicants age 46 and older who have not seen a physician in the last five years may be required to have a paramedical exam completed.

The Standard Rate applies to any applicant who has used tobacco in any form in the last 12 months.

* Note: Not applicable for all states. Refer to state specific guidelines.

Paramedical Exam or Medical Record Procedures:

In an effort to provide better up-front risk selection, an underwriter may request medical records or a paramedical exam on an applicant. This will enable us to determine at the time of application if the applicant has a preexisting condition or any other medical condition that we should rate or rider appropriately. This will improve the management of the business and limit the need for additional investigations at the time of claim.

Medical Records or Attending Physician Statement:

The underwriter will request the medical records for an applicant through Examination Management Service (EMS) and handle any costs associated with obtaining these records. You will be notified of this request through the underwriting status report.

ParaMedical Exam with Lab:

The Underwriter will request a short-form paramedical exam with a blood draw and urinalysis for an applicant through LabOne and handle any costs associated with the exam. You will be notified of the requester through the underwriting status report.

Market Conduct

Accurate & Complete Applications are a Requirement for your Business: As part of your field underwriting responsibility, it is up to you to assure that the applications you submit to us are accurate, complete and true. Any health history disclosed to you must be indicated on the enrollment application, no matter what the condition may be.

With complete information and health history, we can make the best decision on risk selection and coverage approval or disapproval. If you're not sure whether you should submit a specific application, check our Underwriting Guidelines (MAN-GPT30). This guide provides details on many conditions and ailments, showing our underwriting practice for each.

You need to assure accuracy of the application not only for the Home Office, but also for yourself. Submitting inaccurate and incomplete applications can cause delays for your clients at claims time and can also have a serious negative impact on your contract with us and on your career in general.

If we find undisclosed health information through our telephone verification process or through medical records during the underwriting process, we will reject the application. The initial premium will be returned to the applicant. You will also receive a letter explaining that information materially different from that included on the application was discovered during the underwriting process, and a copy of this letter will be forwarded to our Market Conduct Review area within our Corporate Services Department.

Agents who begin to develop a pattern of submitting incomplete or inaccurate applications or who are in some way committing a fraud upon the company will have their contracts terminated.

CRL has the right to deny benefits or rescind coverage if any information on the enrollment application is incorrect, incomplete or untrue.

You can consult the Agent Code of Ethics & Procedures (SEF-S911A) for a complete listing of requirements.

Premium Billing

Premium Payment and Billing Information:

A premium billing statement will be sent to the insured approximately 7-10 days before the due date which is the first day of each month. The total amount due must be submitted with the correct payment coupon and envelope to avoid delays in posting the payment or termination of benefits.

If the insured chooses our convenient electronic fund transfer payment process, he/she will not receive a statement unless the total amount due changes or the insured is billed on a quarterly or semi-annual billing mode. In most instances, the insured will see the total amount due deducted on his/her bank statement. A client can select the following dates for premium to be deducted through the EFT Program: 1st, 10th, 15th or 25th of each month.

An administrative fee for our services is added to each billing statement and is considered part of the total amount due. This charge helps cover the cost of administering the plan for health insurance such as preparation of billing statements, rating and actuarial studies, underwriting, claims processing, certificate materials and computer services. Applicants can save substantially on these fees by selecting EFT (Electronic Funds Transfer).

If payment has not been received within two (2) weeks of the due date, a reminder notice, including a payment coupon and envelope, will be mailed to the insured as a reminder that payment has not been received. If payment is still not received at the time the next billing statement is generated, the billing statement will also include a reminder message.

If payment is not received within the grace period, coverage will automatically terminate at the end of the last billing period the insured paid. A letter will be sent to the insured explaining the termination date and will contain information about applying for reinstatement of coverage. If a check is received after the grace period has expired, the check will be deposited and used to initiate the application for reinstatement process. Additional requirements will be requested through the Managing General Agent. If the member is denied or chooses not to apply for reinstatement, a refund check for the total paid will be sent.

Termination of Coverage:

A courtesy letter is sent approximately 40 days after the due date to the member acknowledging the termination of coverage.

A certificate of creditable coverage is also sent. It contains information regarding consideration for reinstatement.

Reinstatement:

Individuals may be eligible to apply for reinstatement up to 90 days after the date of termination. Reinstatements are subject to approval by CRL, and coverage will not be in effect until the is advised of approval in writing.

If reinstatement is approved, the individual will be billed for all past due premiums and the reinstatement fee. The reinstatement fee is \$15 (if reinstatement is applied for more than three times, the fee changes to \$30). Reinstatements are subject to medical underwriting and a rating, rider, or rejection may be determined according to risk.

Administrative Procedures

Adding Dependents

- Newborns or adopted children will become effective on the eligibility date if CRL receives in its home office a written request from the insured to add the new dependent within thirty-one (31) days after the eligibility date. The eligibility date is determined as follows:
 - For a newborn – the newborn's date of birth; or
 - For an adopted child – the earlier of the date placed for adoption or the legal date of adoption.
 - An application must be completed to add a dependent other than newborns and adopted children. Each dependent will be considered independently and if approved, CRL will determine the effective date of coverage.
 - If a written request to add the newborn or adopted child is not received in CRL's home office within 31 days after the eligibility date, such dependent will be considered independently and if approved, CRL will determine the effective date of coverage.
 - Dependents (other than newborns and adopted children) will be eligible for coverage if a written request is received by the home office prior to the eligibility date (e.g., date of marriage). The effective date will be the eligibility date.
- If the written request is received by the home office within 31 days after the eligibility date, coverage will be effective the first day of the month following receipt of the written request.
 - If CRL is not notified within 31 days after the eligibility date, the member must complete an application for the dependent. The dependent will be considered independently and, if approved, CRL will determine the effective date of coverage.
 - The additional premium charge for the new dependent, if any, will be added to the next premium billing statement and must be paid with the premium when due.
 - No dependent coverage will become effective before the member/individual's coverage is effective.

PPO Network

(for policy/certificate holders with PPO plan option).

1. Policy/certificate holders who move within the state will keep their current network. It will not be necessary to issue a new ID card. The insured, however, will be able to change networks one time during a 12-month rolling period. This can be initiated through a phone call or by written request.
2. Movers into a new state will be assigned to that state's principle network, unless otherwise indicated. If there are multiple networks, The First Health network will be assigned, unless the insured requests a specific network.
3. Students will remain under their parents network. They will have no choice, however, they can take advantage of the travel PPO network.
4. If Ceres Health Care terminates a network, insureds will automatically be enrolled in another network. The insured will be provided with a 30-day written notice.



Checklist for Submission of Association / Individual Business

- Association Insurance Application or Individual Enrollment Application**
Verify applicant's identity by reviewing driver's license or state I.D. or passport
Completed in full with complete medical disclosure
PPO Network selection
Signature of GA/MGA or envelope showing case submitted through their office
Requested effective date
 - **APC-0401** Association Insurance Application
 - **GEORGIA- APL-0542** Individual Enrollment Application
 - **INDIANA- APL-0534** Indiana Association Insurance Application
 - **KANSAS- APL-0143** Individual Enrollment Application
 - **WISCONSIN- APL-0114** Wisconsin Association Insurance Application

- Eagle Consumer Association Membership Application PRO-0033**
It can be waived by signing the Association Insurance application in all other states except Missouri.
 - **MISSOURI:** It is required with all association insurance applications
 - Not applicable in the state of **GEORGIA**. Georgia offering an individual plan.

- Copy of Quote**

- Check made payable to Central Reserve Life**
 - Billing mode indicated

- Payroll Deduction Form- AEF-T068** If desired. (Not permitted in the states of Tennessee and Wisconsin.)
 - **KANSAS- AEF-0372** Payroll Deduction Form

- List Bill Statement AEF-S555** If desired. (Not permitted in the states of Tennessee and Wisconsin.)
 - **KANSAS AEF- 0371** List Bill Form

- Additional required forms for specific states:**
 - **ALABAMA AEF-0310** Alabama Arbitration Form
 - **GEORGIA AEF-0448** Disclosure Notice (leave with client)
 - **GEORGIA PRB-0301** Outline of Coverage (leave with client)
 - **MISSOURI AEF-0580** Addendum to Association Insurance Application
 - **TENNESSEE, WISCONSIN AEF-0259** Statement of Eligibility for Self-Employed (when applicable)

- Writing Agent currently licensed with CRL** (Licensing paperwork can be submitted concurrently in Alabama, Arizona, Illinois, Indiana, Kansas, Missouri, Nevada, Ohio, Tennessee, Virginia.)

(More on back)

Checklist for Submission of Association / Individual Business (continued)

For American Health Value: SEND ALL MSA DOCUMENTS DIRECTLY TO AHV

- Enrollment Application
- Set Up Fee
- Initial Deposit Money

I have reviewed all of the documents being submitted for this case and confirm that all information is complete and all signatures have been affixed.

Submitted by: _____ Signature: _____

MGA/GA Code: _____

Comments on this case:

Enrollment Application Highlights

1 List all the persons proposed for insurance. You will use the numbers of the applicants (1-6) to indicate health conditions in the medical question sections.

2 We are now asking for e-mail addresses for member applicants, which will facilitate more timely communication.

3 Citizenship question. Non-citizens present specific problems in securing medical records and other pertinent information, and this makes them ineligible for coverage.

Page 1

Section 2 includes a number of "gatekeeper" questions, identifying certain medical conditions which make the person ineligible for this insurance. If there are "yes" answers, please be sure to indicate which applicant(s) the answer(s) apply to.

HIPAA eligible section. This section must be filled out to determine eligibility.

Write in the plan name or plan form number for the coverage being applied for. A copy of the proposal for this applicant must be submitted with the application. This will assure that we issue the correct coverage, if approved.

Questions on replacement or no current coverage are critical to underwriting the application.

4 Section 2 includes a number of "gatekeeper" questions, identifying certain medical conditions which make the person ineligible for this insurance.

5 HIPAA eligible section. This section must be filled out to determine eligibility.

6 Write in the plan name or plan form number for the coverage being applied for. A copy of the proposal for this applicant must be submitted with the application.

7 Questions on replacement or no current coverage are critical to underwriting the application.

Page 2

8 Most of the questions on the page are grouped by body system or types of disorders. For any "yes" answers, please be sure to indicate which applicant the information applies to.

Page 3

SECTION 7 BANK AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER

If you want to allow your premiums to be paid by electronic funds transfer:

- Attach a voided check from the account you wish to use.
- Sign below:

Authorization to honor checks drawn by Continental General Insurance Company (CGI)

(In the state of South Carolina, all references to "CGI" are replaced with "The Association")

I authorize you to pay and charge to my account checks drawn by CGI to my account. I agree that this authorization affects the terms of this insurance coverage and I understand that I pay such checks to the account for any reason, with or without notice, and that such non-payment is intentional. I understand that you will be under no liability whatsoever, even though such non-payment results in the forfeiture of insurance. This authorization is to remain in full force and effect until withdrawn in writing from me or its termination. Notice must be received at least ten (10) days prior to the checked withdrawal date to allow the Insurance Company and the necessary an opportunity to act on the request.

Date: _____ (Signature of bank depositor - or show on last month for the account to which the authorization is applicable)

INDEMNIFICATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

TO: The Bank named on voided check.

In consideration of your participation in a plan which Continental General Insurance Company (CGI) has put in effect by which amounts for premiums due on certificates of insurance are collected by drafts drawn by CGI on accounts of persons who have made themselves responsible for these payments, CGI does hereby agree, subject to the terms and provisions of such insurance policies without varying, extending or adding the terms thereof:

- It will indemnify and hold you harmless from any liability to any person having an account with you arising out of the payment by you of any check drawn by CGI on the account for such person, or arising out of the collection by you, whether with or without cause or intention or inadvertence, of any such check drawn by CGI, whether or not such claim of liability asserted against you be based upon the tortious or alleged tortious acts or omissions of insurance, the premiums on which is sought to be collected by CGI by any such check, and
- It will refund to you any amount erroneously paid by you on any such check of claim for the amount of such erroneous payment made by you within a reasonable time from the date of the check on which such erroneous payment was made.

TEAR OFF SECTION BELOW PERFORATION AND LEAVE WITH APPLICANT

NOTICE TO PERSONS PROPOSED FOR INSURANCE

As part of our normal procedure for processing your application, an investigative company report may be prepared whereby information is obtained from the character, general reputation, personal and financial history of the person proposed for insurance in the application. Personal interviews with friends, neighbors and others may be used to develop this report. Only the information collected concerning the usual conduct of the proposed insured will be used to determine his or her eligibility for insurance. If it is reasonable to expect that you have the right to make a written request of the Company to receive additional detailed information about the nature and scope of this investigation.

Information regarding your insurability will be handled as confidential. We or our insurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you wish to have the Bureau removed as a source for their health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request, will supply such company with the information in its file.

17 Authorization for Electronic Funds Transfer. All we require is a signature, selection of draft date and voided check attached. This streamlines the process for you and provides all the information needed.

18 Medical Information Bureau notice. YOU MUST TEAR OFF THIS SECTION AND LEAVE IT WITH THE APPLICANT. Having it perforated at the bottom of the application makes it easy for you to remember and an easy verification for us that you have removed it and left it with the applicant.

Agent Certification. Please fill this in completely. Your signature, e-mail address and other information are required.

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SECTIONS CERTIFICATION OF SOLICITING INSURANCE AGENT

TO CGI: As the soliciting insurance agent, I certify that I have fully explained to this Member all insurance benefits, limitations, exclusions and conditions as set forth in the sales brochure for the selected insurance plan and in soliciting this business. **Have advised this Member not to buy coverage unless and until the Member receives an approval letter from CGI in their Office stating the effective date of coverage.** I certify that I am not aware of any information which might have an adverse effect on the insurability of any person here proposed for insurance.

I further certify that I have reviewed this application, and that it has been completed in full for submission to CGI.

Signed at _____ on this _____ day of _____, 20__

Signature of Soliciting Insurance Agent _____ Agent S. S. # (Resume#) _____ Agent Code _____

Type Name of Agent _____ Agent Address _____ Agent Phone _____

Agent E-mail Address _____ Application taken: In Person By Phone By Mail

TO BE COMPLETED BY GAMGA GAMGA _____ GAMGA Code _____

NOTICE TO PERSONS PROPOSED FOR INSURANCE (continued)

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in its file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 1045, Cross Station, Boston, Massachusetts 02112; telephone number (617) 426-3600.

We, or our insurers, may also release information in our file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

Continental General Insurance Company
 6801 Indian Hills Drive
 P.O. Box 247007
 Omaha, Nebraska 68124-7007



CENTRAL RESERVE LIFE INSURANCE COMPANY
17800 Royalton Road, Cleveland, Ohio 44136-5197
440-572-2400 • www.centralreserve.com

MAN-0030 (12/11/03)
