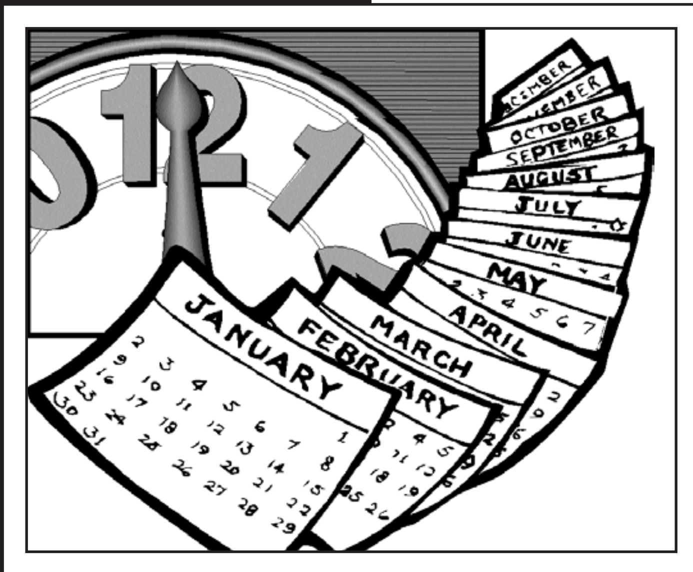
SHORT-TERM MEDICAL INSURANCE POLICY
INDIVIDUALS AND FAMILIES



$2,000,000 Temporary Health Insurance

Medical coverage when you need it.

- Between jobs
- Recently graduated
- On school vacation
- Newly employed and waiting for coverage under your company policy

Form STP-B

WHO IS ELIGIBLE FOR THE POLICY?

People who are healthy issued up to age 64 and 11 months. This includes your spouse and unmarried dependent children of your household through age 19 (23 if a full-time student). Dependents born while the policy is in force are covered from date of birth at no extra cost. **PLEASE NOTE: An individual cannot apply for coverage that will run into the month in which he or she reaches age 65.**

WHO IS NOT ELIGIBLE FOR THE POLICY?

- Those who have been declined for insurance for health reasons or who have health conditions that would make them ineligible for a fully underwritten policy of insurance.
- Those who will turn 65 or become eligible for Medicare during the Benefit Period.
- Those who are pregnant or have a family member who is pregnant.
- Those who have other medical coverage in force that will not terminate prior to the effective date of the policy.
- Foreign visitors or Non-U.S. Citizens or those who will be traveling outside the U.S.A.
- Persons who have occupations involving unusual hazards.
- Persons who have any other hospital insurance coverage (individual or group).

WHEN DOES MY COVERAGE BEGIN?

Coverage takes effect on the later of: 1) 12:01 a.m. on your requested Policy Date; or 2) 12:01 a.m. the day after the postmark date affixed by the United States Post Office. Please refer to the provision of the policy entitled, "When Coverage Begins and Ends."

HOW DOES THE POLICY WORK?

YOU satisfy the Deductible Amount* elected. (The deductible options are $250, $500, $1,000, or $2,500.**)

THEN, you pay 20% (50% if 50/50 option chose) of the next $5,000 of Covered Expenses.

THEREAFTER, Central Reserve Life Insurance Company pays 100% of the remaining Covered Expenses up to the policy maximum of $2,000,000 for each Covered Person per Benefit Period.

** The Deductible Amount is the larger of: (a) the Deductible Amount selected; or (b) the amount of benefits paid by any other health insurance plan.*

*** A Maximum Family Deductible equal to 3 times the Deductible Amount will satisfy the Deductible requirement for all covered family members.*

PRE-EXISTING CONDITIONS ARE NEVER COVERED UNDER THE POLICY.

CRL's Short-Term Medical Insurance Policy NEVER pays for pre-existing conditions. A pre-existing condition is a condition: for which medical advice was given or treatment was recommended by a physician within five years (2 years in IL and WV) prior to the Policy Date; or which produced symptoms which would cause an ordinarily prudent person to seek medical care, treatment or diagnosis[9] within five years (12 months in IL and 2 years WV) prior to the Policy Date.

WHAT HAPPENS IF FURTHER TREATMENT IS REQUIRED AFTER MY POLICY EXPIRES?

When insurance ends, benefits may be extended for Covered Expenses for Sickness which began while the Policy was in force and which is the cause of the Total Disability. Benefits will be extended for that Covered Person only while Totally Disabled and under the care of a Physician for the disability. This does not apply to a disability related to pregnancy. CRL will extend benefits to the earliest of: (a) the date that continuous Total Disability ends; (b) payment of the maximum benefit; or (c) a period of time equal to the Benefit Period as shown on the Policy Schedule.

MAY I PURCHASE A SECOND POLICY?

CRL's Short-Term Medical Insurance Policy is NON-RENEWABLE. You may apply for one additional Benefit Period, NOT to exceed a TOTAL maximum coverage period of 12 months (6 months in OH) for the two policies. A new application must be completed. Should a second application be approved, a new policy will be issued. THERE IS NO CONTINUOUS COVERAGE between the original and second policy. Any conditions or symptoms which may have occurred under the first policy will be treated as pre-existing under the second policy.

HOW TO GET STARTED

Please review the Eligibility Section of this brochure. Apply only if you meet those requirements.

1. Locate rate information and premium calculation instructions on back of application.
2. Complete all items on the application. Be sure to sign and date the application.
3. Make your check or money order payable to Central Reserve Life Insurance Company. You may charge your initial and subsequent or full single-pay premium to your VISA/MasterCard.
4. Insert application in an envelope with your payment and mail.

WHAT ABOUT REFUNDS?

You may return your policy for a full refund within 10 days of delivery. After that time, refunds are not available.

[9] IL and WV– Delete "which would cause an ordinarily prudent person to seek medical care, treatment or diagnosis"

OUTLINE OF COVERAGE FOR POLICY FORM STP

READ YOUR POLICY CAREFULLY

This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and us. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

SHORT-TERM MEDICAL INSURANCE

Short-term medical insurance policies are designed to provide to persons insured coverage for major hospital, medical, and surgical expenses incurred for a specific benefit period.

USUAL AND CUSTOMARY

The policy will provide benefits for Covered Expenses up to usual and customary charges. Usual and customary means the charge made for services or supplies by qualified persons or institutions that are usual and customary in the geographic area where service is rendered.

PRECERTIFICATION

Precertification is not required in all states. In certain states hospital confinements and surgeries require precertification. Non-emergency admissions and surgeries must be certified at least 72 hours prior to receiving care. Emergency admissions and surgery must be certified within 48 hours after admission. If precertification is not obtained, benefits for covered expenses will be subject to an additional deductible of $500.

COVERED EXPENSES

Hospital room and board; intensive care confinement; other medically necessary hospital services; ground ambulance; treatment by a physician; additional surgical opinions; anesthesia; radium therapy, x-ray treatments and exams; spinal manipulation; ambulatory surgical facility; surgical and nonsurgical treatment of TMJ and CMD; PKU treatment; drugs and medicines, blood, artificial limbs or eyes; rental of durable medical equipment; surgical services for breast reconstruction; mammography; and preventive child health supervision services and immunizations.[1 234]

LIMITED BENEFITS

Maximum Benefit for organ transplants per Insured Person of all Covered Charges for heart transplant is $100,000; liver transplant is $100,000; bone marrow transplant is $50,000; kidney transplant is $25,000; all other covered transplants are $25,000.

Mental or nervous disorders benefits are payable at 25% of Covered Expenses while hospital confined and are limited to $5,000 per Benefit Period.

EXCLUSIONS

Injury or sickness covered by Worker's Compensation or Occupational Disease Laws; injury or sickness resulting from an act of war, declared or undeclared; suicide or attempted suicide; intentionally self-inflicted injury or sickness; injury sustained or sickness that begins while in the armed services; confinement in a US Government hospital or facility; atomic explosion or radiation sickness or disease; routine physical exams; surgery or treatment considered by us to be experimental; a transplant of a part of your body to the body of another person; dental care and treatment; cosmetic surgery; alcoholism or drug treatment; eyeglasses, hearing aids, or contact lenses; well baby care; injury received in an aircraft while serving as pilot or crew member; elective abortion; normal pregnancy or prenatal care; purchase or rental of air conditioners, dehumidifiers, air purifiers; infertility treatment; genetic testing; treatment, medication or hormones to stimulate growth; weight reduction; learning disabilities; treatment, repair or removal of tonsils or adenoids, except in an emergency; complications of any treatment or surgery for an excluded service or procedure; expense incurred while the policy is not in force; radial keratotomy; automated lamellar or keratoplasty; and total parenteral nutrition.

The policy does not provide benefits for loss due to a pre-existing condition.

[1] *Oklahoma – Add: 48 hours of inpatient care following a mastectomy and 24 hours of inpatient care following lymph node dissection.*
[2] *West Virginia – Add: rehabilitation services and annual pap smear.*
[3] *Illinois – Delete: atomic explosion or radiation sickness or disease.*
[4] *Oklahoma – Delete: injury sustained or sickness that begins while in the armed services and repair or removal of tonsils or adenoids, except in an emergency.*

THIS PAMPHLET PROVIDES A BRIEF DESCRIPTION OF SOME OF THE IMPORTANT FEATURES OF INSURANCE POLICY Form STP
THIS IS NOT THE INSURANCE CONTRACT AND ONLY THE ACTUAL POLICY PROVISIONS WILL CONTROL.

RETAIN THIS PORTION FOR YOUR RECORDS:

On___________________ I mailed an application and a check for $_____________ to Central Reserve Life Insurance Company. I selected a Benefit Period of:__________________________

PREMIUM CALCULATION WORKSHEET

PAY-AS-YOU-GO

1. Choose your deductible ($250, $500, $1,000, $2,500). _______
2. Find each applicant's monthly rate under your deductible choice. (Minimum 2 month Benefit Period)

   Multiply each child rate ($ __________)

   X (number of children __________) =
3. Enter #2 in the #3 Subtotal line
4. Locate your area factor under the first 3 digits of your area code. Multiply #3 Subtotal by your area factor.
5. If applicable, add amount for Optional Rider or Mandated Benefit to #4 Subtotal.
6. Add $12.50 Administrative Fee.

Male	$	________
Female	+ $	________
Child (ren)	+ $	________
#2 Subtotal	$	________
(x 80%) (applies to one time pay only)		
#3 Subtotal	$	________
Area Factor	x	________
#4 Subtotal	$	________
(if applicable)	+ $	________
#5 Subtotal	$	________
(# of months)	(x	________)
TOTAL PREMIUM	= $	________
Administrative Fee	+ $	12.50
TOTAL	= $	________

Transfer this amount to the application.

SINGLE PAY PLAN

1. Choose your deductible ($250, $500, $1,000, $2,500). _______
2. Find each applicant's monthly rate under your deductible choice. (Minimum 2 month Benefit Period)

   Multiply each child rate ($ __________)

   X (number of children __________) =
3. Multiply #2 Subtotal by 80%.
4. Locate your area factor under the first 3 digits of your area code. Multiply #3 Subtotal by your area factor.
5. If applicable, add amount for Optional Rider or Mandated Benefit to #4 Subtotal.
6. Multiply #5 Subtotal by the # of months of coverage needed.
7. Add $12.50 Administrative Fee.

MONTHLY* RATE TABLE — FORM STP — PREMIUM FOR EACH MONTH OF COVERAGE**

	$250 Deductible		$500 Deductible		$1,000 Deductible		$2,500 Deductible	
AGE	M	F	M	F	M	F	M	F
0-24	$84.00	$100.00	$68.00	$80.00	$54.00	$61.00	$39.00	$45.00
25-29	$94.00	$116.00	$71.00	$86.00	$54.00	$63.00	$39.00	$46.00
30-34	$100.00	$134.00	$81.00	$106.00	$58.00	$79.00	$41.00	$59.00
35-39	$126.00	$156.00	$100.00	$125.00	$71.00	$93.00	$60.00	$69.00
40-44	$144.00	$170.00	$118.00	$136.00	$89.00	$105.00	$66.00	$79.00
45-49	$175.00	$198.00	$138.00	$156.00	$113.00	$125.00	$85.00	$94.00
50-54	$234.00	$234.00	$184.00	$184.00	$146.00	$141.00	$109.00	$105.00
55-59	$301.00	$291.00	$256.00	$233.00	$204.00	$181.00	$153.00	$135.00
60-64	$465.00	$344.00	$369.00	$271.00	$288.00	$210.00	$215.00	$158.00
Each Child	$63.00	$63.00	$50.00	$50.00	$41.00	$41.00	$31.00	$31.00

* *Daily option only available with Single Pay Plan. To obtain daily rate, divide monthly rate by 30 and multiply by number of days of coverage.*

***Rates shown are based on the 80/20 coinsurance option. To obtain the 20% premium discount for the 50/50 coinsurance option, multiply the Total Premium on the Premium Calculation Worksheet by .80. (N/A in OK).*

AREA FACTORS

Area factors are based on the first three digits of the resident address. Zip codes shown together (Example: 600-605) are inclusive.

ALABAMA	1.30
ILLINOIS	.90
600-605	1.20
606	1.60
NEBRASKA	.80
OHIO	.90
439-442	1.20
OKLAHOMA	.90
730, 731, 741	1.10
WEST VIRGINIA	.90

APPLICATION TO CENTRAL RESERVE LIFE INSURANCE COMPANY (CRL)

REQUESTED POLICY DATE

MONTH	DAY	YEAR

Applicant: Name ______ Date of Birth ______ Age ______ Sex ______

Social Security Number ______ Telephone Number ______

Street Address ______ City ______ State ______ Zip ______

COMPLETE THE FOLLOWING TO INSURE YOUR SPOUSE AND / OR CHILDREN

Spouse's Name ______ **Social Security Number** ______

Date of Birth ______ Age ______ Sex ______

Child's Name ______ Date of Birth ______ Age ______ Social Security Number ______

Child's Name ______ Date of Birth ______ Age ______ Social Security Number ______

Child's Name ______ Date of Birth ______ Age ______ Social Security Number ______

COINSURANCE OPTION	**TERM OF COVERAGE** (Benefit Period, in months)	**DEDUCTIBLE AMOUNT** (check one)	**PREMIUM OPTIONS**
❑ 80/20 ❑ 50/50 (N/A in OK)	______ 60-365 Days (Min. -2 months, Max. 12 months) (Max.-6 months in AZ, DE, NV, OH) (Daily Coverage is available for Single Pay Plan	❑ $250 ❑ $1000 ❑ $500 ❑ $2500	❑ Monthly Premium Option (Pay-As-You-Go) ❑ Entire Amount of Premium for Benefit Period Selected (Single Pay Plan) TOTAL PREMIUM PAID $ ______

❑ Check
❑ Visa/MasterCard*
*(N/A in AL)

PREMIUM PAYMENT METHOD

Credit Card Number: ______ Expiration Date: ______ Initial ______

If Credit Card, I authorize CRL to bill my VISA/MasterCard account for the initial or subsequent premium or all the premium due.

Answer the following questions completely and accurately.

Question	APPLICANT	SPOUSE	CHILD(REN)
1. Will this insurance replace coverage in any company? If yes, provide the name of the Company, Type of Policy, and Date it terminates: ______	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
2. Have you applied (or have pending applications) for any other health insurance coverage? If yes, please explain ______	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No

IF YOU ANSWER "YES" TO QUESTIONS 3 THRU 9 BELOW DO NOT SUBMIT THIS APPLICATION AS COVERAGE CANNOT BE ISSUED.

Question	APPLICANT	SPOUSE	CHILD(REN)
3. Do you or any person to be insured have any hospital, major medical, group health, or medical insurance coverage in force that will not terminate prior to the effective date of this coverage?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
4. Have you or any person to be insured been declined for insurance due to health reasons? (Not to be completed by residents of AZ and OH)	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
5. Are you, your spouse, or any dependent (whether or not listed on this application) now pregnant?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
6. Is any person to be insured not a U.S. Citizen?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
7. Within the last 5 years, has any person to be insured been treated or been diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
8. Within the last 5 years, has any person to be insured ever received any medical or surgical consultation, advice, treatment, medication for, or had any of the following conditions noted below: Internal Cancer; Leukemia; Hodgkin's Disease; any tumors or lumps; Heart Attack; Angina; Heart Disease; High Blood Pressure (not under control); Stroke or Paralysis; Alcohol Abuse; Drug or Substance Abuse, Addiction or Dependence; Emotional, psychological, psychiatric, or nervous condition, disease or disorder; Tested HIV positive; Hepatitis (other than virus A); Cirrhosis of Liver; Multiple Sclerosis or Cerebral Palsy; Ulcerative Colitis; Diabetes; Epilepsy; Cataracts; Hernia (uncorrected);Degenerative Arthritis.	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
9 Are you or any person to be insured currently confined in a hospital or have been hospitalized more than 2 times within the past 12 months?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No

I have read this application and agree that all statements and answers are true and complete. I understand the following: (a) if any information stated in this application is incorrect, coverage may be voided; and (b) benefits are not payable for a Pre-Existing Condition (including conditions not fully disclosed on this application); (c) that coverage will take effect on the later of: 12:01 a.m. the day of my requested policy date; or 12:01 a.m. the day after the postmark date affixed by the United States Post Office; and (d) if the application is declined and coverage is not issued, CRL's only obligation will be to return any premium paid.

I have received the Outline of Coverage? ❑ Yes ❑ No

I represent/certify that the following information is correct and true as it relates to the health insurance being applied for:

No part of the premiums or benefits for the policy will be paid by an employer nor will premium payments be paid by an employer through payroll deduction; No person covered by the policy will be reimbursed through wage adjustments or any other method by an employer for any portion of the premium; and the health insurance will not be treated by an employer or any of the persons insured as part of a plan or program for the purpose of Section 106, Section 125 or Section 162 of the U.S. Internal Revenue Code.

APPLICATION AUTHORIZATION

I hereby authorize any health care provider, including any physician, practitioner, pharmacy, hospital or medically-related facility, and any insurance company, employer, or, except in AZ and WI, any other organization, institution or person that has my records or knowledge of me or my dependent(s) to disclose to CRL, or its authorized representative, any such records or information. Records or information may include medical records in their entirety, which may contain mental health records (excluding psychotherapy notes), prescription drug records, use of alcohol, or use of controlled or prohibited substances, driving records, financial and employment records. Such records or information will be used by company personnel to determine eligibility for insurance and/or benefits. CRL may disclose such information to its reinsurer(s), precertification firm, individual benefits management firms or any other organization which performs services in connection with the insurance relationship, including, but not limited to, the insurance agent, or as lawfully required. CRL reserves the right to require a medical examination or testing or both. There may be certain circumstances under which the information received may be disclosed to third parties who are not subject to the regulations under federal health privacy law. We contractually require such persons to agree to protect the confidentiality of the information. I understand that I have the right to request access to all personal information collected and, upon written request, I may ask CRL to correct, amend or delete any incorrect personal information. A copy of the Company's "Privacy Notice and Notice of Insurance Information Practices" is available upon request.

This authorization shall be valid for a period of two (2) years from the date signed to determine eligibility for insurance. For determination of benefits, the authorization shall be valid for either the term of coverage of the policy for health insurance products or for the duration of the claim for all other insurance products. A photocopy of this authorization shall be as valid as the original. I understand that I, or my authorized representative may receive a copy of this authorization upon request. This authorization may be revoked at any time subject to the rights of anyone who acted in reliance upon the authorization prior to notice of its revocation. This authorization may be revoked upon submission of a written notice to the Home Office. If this authorization was obtained as a condition of obtaining insurance coverage, your right to revoke also is subject to the rights of the Company under any law granting the Company the right to contest a claim under the policy or the policy itself. Revocation or failure to sign the authorization may be a basis for denying an application or eligibility for benefits.

NOTICE: For Ohio Residents only: We are required by Ohio law to inform you of the following: "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits and application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

NOTICE: For Oklahoma residents only: We are required by Oklahoma law to inform you of the following: "WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony."

APPLICATION DATED AT: ______________________ on ______________, ________
City State

Signature of Applicant: ______________________ Date: ________
(Signature of Parent or Legal Guardian required if child is under 18)

Signature of Spouse: ______________________ Date: ________
(If applying for coverage)

Signature of Adult Child: ______________________ Date: ________
(If applying for coverage)

Signature of Adult Child: ______________________ Date: ________
(If applying for coverage)

Signature of Adult Child: ______________________ Date: ________
(If applying for coverage)

Signature of Authorized Representative: ______________________ Relationship/ Authority to Represent: ________ Date: ________

Authorized Representative's Address: ______________________

Authorized Representative's Phone Number: ______________________

FOR AGENT USE ONLY	Please Print AGENT NAME: ________ AGENT NUMBER: ________ ADDRESS: ________ (STREET) (CITY, STATE, ZIP CODE)	FOR AGENT USE ONLY	MAKE CHECK PAYABLE TO: CENTRAL RESERVE LIFE INSURANCE COMPANY P.O. Box 247007, Omaha, NE 68124-7007

Our Commitment

At Central Reserve Life, we are committed to valuable service and health insurance products at affordable prices. Our mission is to fully serve the needs of all those associated with our company.

CENTRAL RESERVE'S SHORT-TERM MEDICAL INSURANCE POLICY

Temporary medical protection designed for the person who is between permanent health policies.

No physicals to take... no long medical histories to complete.

Short-Term Medical Plan Administration By:
Continental General Insurance Company
Omaha, Nebraska

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

PRO-0541 (Rev. 8/3/05)