



## Assurant Health Access<sup>SM</sup>

### *Only a few medical questions to qualify*

Thank you for applying for an Assurant Health Access plan. It's important you understand the benefits and limitations of these fixed-indemnity plans with limited benefits — plans that pay a set amount when you receive particular services. Please review the product brochure and talk with your agent to make sure this type of plan is right for you.

### Follow these steps to enroll now!

1. **Decide whom you want to cover** — just you, you and your spouse, just your children, or your entire family. If more than one adult is applying, choose the youngest adult as the primary applicant.
2. **Decide which level of benefits is right for you** — Value, Fundamentals or Enhanced.
3. **Decide if you want additional coverage.**
  - **SuiteSolutions®** — help pay out-of-pocket health expenses by purchasing an upgrade to the basic Health Advocates Alliance membership.
  - **Assurant Supplemental Coverage** — ask your agent if Accident, Critical Illness and Dental coverage are available in your state.
4. **Calculate your total premium** — transfer the monthly rate/fee from your choices to the calculation table to determine your total monthly premium.
5. **Start the enrollment process for your plan** — please note there is a non-refundable \$25 processing fee.
6. **For quick approval, fully complete the enrollment form with your agent, including:**
  - All required questions
  - Requested effective date (must be the 1st or 15th of the month; see enrollment form for details)
  - Signatures for all applicants age 18 and older (child-only policies need a custodial parent or guardian signature)

### EXISTING CUSTOMERS

To add a spouse or dependent, or to apply for reinstatement of an Assurant Health Access plan, please complete the enrollment form in this packet, including the "ARE YOU AN EXISTING CUSTOMER?" section. Please do not include any premium payment with the completed enrollment form.

For in force B or C plans, please refer to Plan B or C In force - Underwriting Change Packet.

Please note that no benefits are provided for any medical events that occur between the date this enrollment form is signed and the effective date of the plan. Additionally, the plan does not pay benefits for events that result from or are related to a pre-existing condition, or its complication(s), until the covered person has been continuously insured for 12 months following the effective date.

**Agent: please leave this sheet with your client.**



*Applies to plans issued with effective dates June 1, 2011, and later*

Get quick pricing information on Assurant Health Access plans by choosing from the options listed below. For the rates and optional coverage, **circle** the monthly rate and then **copy** the numbers into the **CALCULATE YOUR TOTAL PREMIUM** box on page 2.

Be sure this name matches the primary applicant's name on the enrollment form, Line 1.

**Complete the details below for the primary applicant:**

PLEASE PRINT USING BLACK INK

Last Name (please print) First Name (please print) MI Date of Birth State of Residence

**Attention agents:** Be sure the Rate Sheet is complete and fax **both pages**, along with the enrollment form, to 414.299.6020. Provide your name and contact information to your client (you also can stamp the back of the brochure).

**1. Choose your level of benefits, the applicants and the age of the primary applicant:**

Circle the monthly premium rate.

If more than one adult is applying, choose the youngest adult as the primary applicant.

For child-only plans, the youngest is the primary applicant.



<b>VALUE — Assurant Health Access Monthly Rates</b>					
AGE	0-17	18-30	31-40	41-50	51-63
Primary	\$54.00	\$67.00	\$74.00	\$94.00	\$144.00
Primary and Spouse	\$108.00	\$134.00	\$148.00	\$188.00	\$288.00
Primary with 1 child	\$108.00	\$121.00	\$128.00	\$148.00	\$198.00
Primary with 2 or more children	\$184.00	\$197.00	\$204.00	\$224.00	\$274.00
Primary and Spouse with 1 child	\$162.00	\$188.00	\$202.00	\$242.00	\$342.00
Primary and Spouse with 2 or more children	\$246.00	\$272.00	\$286.00	\$326.00	\$426.00

<b>FUNDAMENTALS — Assurant Health Access Monthly Rates</b>					
AGE	0-17	18-30	31-40	41-50	51-63
Primary	\$89.00	\$109.00	\$119.00	\$159.00	\$249.00
Primary and Spouse	\$178.00	\$218.00	\$238.00	\$318.00	\$498.00
Primary with 1 child	\$178.00	\$198.00	\$208.00	\$248.00	\$338.00
Primary with 2 or more children	\$303.00	\$323.00	\$333.00	\$373.00	\$463.00
Primary and Spouse with 1 child	\$267.00	\$307.00	\$327.00	\$407.00	\$587.00
Primary and Spouse with 2 or more children	\$405.00	\$445.00	\$465.00	\$545.00	\$725.00

<b>ENHANCED — Assurant Health Access Monthly Rates</b>					
AGE	0-17	18-30	31-40	41-50	51-63
Primary	\$139.00	\$169.00	\$189.00	\$249.00	\$386.00
Primary and Spouse	\$278.00	\$338.00	\$378.00	\$498.00	\$772.00
Primary with 1 child	\$278.00	\$308.00	\$328.00	\$388.00	\$525.00
Primary with 2 or more children	\$473.00	\$503.00	\$523.00	\$583.00	\$720.00
Primary and Spouse with 1 child	\$417.00	\$477.00	\$517.00	\$637.00	\$911.00
Primary and Spouse with 2 or more children	\$632.00	\$692.00	\$732.00	\$852.00	\$1,126.00

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

The rates for this fixed-indemnity plan with limited benefits are only valid for plans issued with effective dates June 1, 2011, 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 applicant's age as of the effective date of the plan. Final rates may vary. All rates are subject to underwriting approval.

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

# Assurant Health Access Rate Sheet

\_\_\_\_\_  
Last Name (please print) First Name (please print) MI Date of Birth State of Residence

This membership is required; see footnote.\*

## HEALTH ADVOCATES ALLIANCE (HAA) MEMBERSHIP\* - REQUIRED

Membership in HAA is required and provides additional benefits and discounts for a variety of services – for members only.

**\$4.00 per month**

## 2. Make your plan 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 plan covers more than one person.

**SuiteSolutions\*\* – 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	Monthly fee to Upgrade HAA Membership		SelectSolution	Monthly fee to Upgrade HAA Membership	
	Single	Family		Single	Family
Accident Medical Expense Benefit Level			Accident Medical Expense and Critical Illness Expense Benefit Level		
\$2,500	\$34.95	\$44.95	\$2,500	\$50.95	\$60.95
\$5,000	\$38.95	\$48.95	\$5,000	\$54.95	\$64.95
\$10,000	\$43.95	\$58.95	\$10,000	\$64.95	\$74.95

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

Need extra coverage? Look at some of the additional options available to you, then talk to your agent.

**Ask your agent if additional Assurant Supplemental Coverage options including Accident, Critical Illness and Dental coverage are available in your state.**

## 3. Calculate your total premium

BENEFITS	MONTHLY RATE/FEE		
	VALUE	FUNDAMENTALS	ENHANCED
Circle the benefit level you've chosen			
Assurant Health Access monthly rate			
Health Advocates Alliance (HAA) membership fee	+	\$4.00	
SuiteSolutions upgraded HAA membership fee	+		
<b>TOTAL MONTHLY PREMIUM</b>	=		
One-time processing fee (non-refundable)	+	\$25.00	
<b>TOTAL INITIAL PAYMENT</b>	=		

**Please note the processing fee will not be returned regardless of whether the plan is issued.**

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

\*Membership in Health Advocates Alliance is required to buy this Assurant Health plan. 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.

\*\*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, PA, a subsidiary of Chartis Insurance Company.

Form 49903 (New 4/2011) © 2011 Assurant Inc. All rights reserved.

# Assurant Health Access enrollment form for hospital confinement and surgical fixed indemnity insurance plan

PLEASE PRINT IN BLACK INK  
 Time Insurance Company  
 501 West Michigan  
 Milwaukee, WI 53203

## 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/domestic partner and dependent information if it applies.

	Last	Name First	MI	Sex	Birthdate (MM/DD/YY)	State of Birth	Social Security Number
1. Primary							
2. Spouse / Domestic Partner							
	Last	Name First	MI	Sex	Birthdate (MM/DD/YY)	Full-time student?	Social Security Number
3. Dependents (list relationship below)							
A.							
B.							
C.							
D.							

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

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

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

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

7a. 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.

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?

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

## 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

Assurant Health 501 West Michigan Milwaukee, WI 53203

**HEALTH STATEMENT**

To determine if you're eligible for this hospital confinement and surgical fixed indemnity insurance plan, you need to answer a few medical questions for you and anyone else applying for this plan.

*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.**

Primary Spouse/Domestic Partner  
 Enter dependent information in same order as page 1.  
 A: B: C: D:

- |  |  |
|--|--|
| <p>9. 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 Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC)? 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.</p>  | <p>Yes <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>No <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> |
| <p>10. 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?</p>   | <p>Yes <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>No <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> |
| <p>11. Are you, your spouse or any person to be insured totally and permanently disabled and/or receiving long-term disability benefits?</p>   | <p>Yes <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>No <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> |
| <p>12. 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:</p> <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 or Brain Aneurysm</li> <li>• Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)</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, Chronic Obstructive Pulmonary Disease (COPD), Fibrotic Lung Disease or Primary Pulmonary Hypertension</li> <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 a surgery or procedure whose purpose is to promote weight-loss</li> <li>• Autism Spectrum Disorders, Autism, Asperger's Disorder, Rett's Syndrome, Pervasive Developmental Disorders or Pervasive Developmental Delay</li> </ul> | <p>Yes <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>No <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> |

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

**Assurant Health 501 West Michigan Milwaukee, WI 53203**

**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 a an Electronic Funds Transfer (EFT) / Check-O-Matic draft date that is the same as your effective date.

The accountholder's signature is needed here if requesting Electronic Funds Transfer (EFT) /Check-O-Matic.

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**

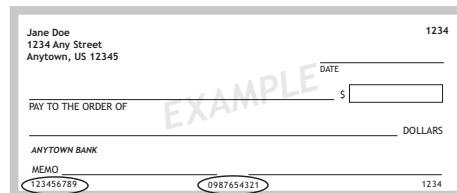
→ To begin withdrawals:  
Select a desired withdrawal date 1-28: \_\_\_\_\_

Bank name: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Routing number: \_\_\_\_\_

Account number: \_\_\_\_\_



Routing Number Account Number  
9 digits

→ To add this policy to an existing Electronic Funds Transfer (EFT) /Check-O-Matic

Existing Electronic Funds Transfer (EFT) /Check-O-Matic

number: \_\_\_\_\_

Associated policy number: \_\_\_\_\_

Authorization for Electronic Funds Transfer (EFT) /Check-O-Matic – **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, 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:  Monthly  Quarterly  Semi-Annual  Annual  
or  
→  Charge first payment only\*

*\*You must also select a secondary billing method other than payroll deduction (list bill) for subsequent payments. Once you choose below, go to that section and complete.*

Choose method:  Payroll deduction (list bill)

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

Bill me directly

Authorization for credit card payments – **please sign below**  
I authorize Time Insurance Company to charge my account for the hospital confinement and surgical fixed indemnity insurance plan. 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: \_\_\_\_\_

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Assurant Health 501 West Michigan Milwaukee, WI 53203

(Rev. 4/2011)

**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 this plan. 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 the insurance plan. 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 - Fixed Indemnity Plan (Form 30235).

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

**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 a group non-employer related hospital confinement and surgical fixed indemnity insurance plan for you (and your family). You further understand that this enrollment form will be medically underwritten, and that eligibility for this plan is not guaranteed. You are personally paying the entire premium for this plan. Your employer is not contributing in any way to the payment of premium, either directly or indirectly.

Do you agree with these statements?.....  Yes  No

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Assurant Health 501 West Michigan Milwaukee, WI 53203

(Rev. 4/2011)

## AUTHORIZATION

Signatures are needed in this section. It's important to note you are applying for a hospital confinement and surgical fixed indemnity insurance plan. This plan comes with a 10-day free look.

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

I understand the insurance plan 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 enrollment process may be shared with persons necessary to facilitate issuing this plan, 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, Examination Management Services, Inc. (EMSI), 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, Human Immunodeficiency Virus (HIV) testing and treatment, sexually transmitted disease (STD) testing and treatment, sickle cell testing and treatment, prescription history, lab data and electrocardiograms (EKGs). This information may also be disclosed to MIB, 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, 501 West Michigan, 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 this plan, if required.

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**Assurant Health 501 West Michigan Milwaukee, WI 53203**

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 fraudulent statement or 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 plan I am applying for is a fixed indemnity benefit plan and has specific benefit limitations. This plan is not major medical insurance coverage or a Medicare Supplement Plan.

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

\_\_\_\_\_  
Signature of Spouse/Domestic Partner  
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: \$ \_\_\_\_\_

One-time Processing Fee Sent\*: \$ \_\_\_\_\_  
*\*Not applicable in all states*

\_\_\_\_\_  
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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Assurant Health 501 West Michigan Milwaukee, WI 53203

**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 this plan
- 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**

**Assurant Health 501 West Michigan Milwaukee, WI 53203**

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

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

### **NOTIFICATION REGARDING MIB, Inc. (“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 about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of the 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 Park, Suite 400, Braintree, Massachusetts 02184-8734.

Time Insurance Company, or its reinsurers, may also release information from 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**

**Assurant Health 501 West Michigan Milwaukee, WI 53203**