ASSURANT Health®

Client Tip Sheet

INDIANA

Medical Insurance for Individuals and Families

Thank you for applying for Medical Insurance for Individuals and Families. Please review the product materials so you understand the benefits of these plans. Talk to your agent to make sure the plan you're applying for suits your needs.

Follow these steps to enroll now!

1. Determine with your agent the plan that's right for you.
2. Decide whom you want to cover.
3. Ask your agent to run an online quote to determine the appropriate rate and effective date for the coverage you select. Valid effective dates are either the 1st or 15th of the month.

   For enrollment forms signed the 1st through the 15th of the month, the following effective dates are available:
   - 1st of the following month
   - 15th of the following month
   - 1st of the 2nd month
   - 15th of the 2nd month

   For enrollment forms signed the 16th through the 31st of the month, the following effective dates are available:
   - 15th of the following month
   - 1st of the 2nd month
   - 15th of the 2nd month
   - 1st of the 3rd month

4. To apply for coverage, please complete and return the following:
   - Enrollment form*
   - Billing Selection Worksheet
   - Agent quote (all pages)

Your agent will submit the completed forms and keep you updated on the status.

*Due to the Individual Mandate of the Affordable Care Act (ACA), it is recommended that you provide your Social Security Number (SSN) as well as the SSN of any dependents. By providing your SSN, we will be able to accurately report to the federal government that you (and your dependents) have Minimum Essential Coverage (MEC).

AGENT: Refer to the Agent's Guide, (J-109630) for eligibility and signature requirements. Please leave the "Important Notices—Medical" and the "Important Notice to Persons on Medicare" pages with the customer. Fax all other pages to 414.299.6020.

Enrollment Form for Medical Insurance for Individuals and Families

PLEASE PRINT IN BLACK INK

AGENT/AGENCY INFORMATION

Agent Name: Ryan Kennelly

Agent Number: 000471FN000001

Key Agency Contact: Ryan Kennelly

Fax Number: 847-220-9280

Phone Number: 630-930-9364

Email Address: ryan@ilhealthagents.com

Agency Name: Illinois Health Agents, Inc.

Agency Number: _____

TYPE OF ACTIVITY *(Please check appropriate box.)*

☐ Initial Enrollment

☐ Life Event

☐ **CHANGE/ADDITION TO AN EXISTING POLICY. POLICY #** _____

- ☐ Adding Spouse/Dependent
- ☐ Internal Replacement
- ☐ Removal of Tobacco Rates
- ☐ Conversion (over age dependent/divorce)
- ☐ Policy/Benefit Change to an Existing Policy
  List Type of Change Requested: _____
- ☐ Reinstatement of Coverage

PERSON(S) TO BE INSURED

If additional space is needed, use the ADDITIONAL NOTES section.

	Name *Last*	*First*	*M.I.*	Sex	Birthdate *(MM/DD/YY)*	Relationship	Social Security Number
1. PRIMARY							
2. SPOUSE							
3. DEPENDENT 1							
4. DEPENDENT 2							
5. DEPENDENT 3							
6. DEPENDENT 4							

7a. Resident Address: _____
(No P.O. Boxes) *(Street)* *(City)* *(County)* *(State)* *(ZIP)*

7b. Email Address: _____

By providing your email address you agree that you may receive your policy and/or certificate of issuance and other correspondence electronically.

8. Phone Number you can be reached at, including area code: _____

FAX ALL PAGES EXCEPT "IMPORTANT NOTICES - MEDICAL" TO 414.299.6020

	PRIMARY	SPOUSE	DEPENDENT 1	DEPENDENT 2	DEPENDENT 3	DEPENDENT 4
9a. Are you a U.S. citizen or national? Yes	☐	☐	☐	☐	☐	☐
No	☐	☐	☐	☐	☐	☐
9b. If not a U.S. citizen or national, do you have eligible immigration status? Yes	☐	☐	☐	☐	☐	☐
No	☐	☐	☐	☐	☐	☐

If "Yes", complete the section below.

Name: _____ Document Type: _____ ID Number: _____

Name: _____ Document Type: _____ ID Number: _____

Name: _____ Document Type: _____ ID Number: _____

Name: _____ Document Type: _____ ID Number: _____

Name: _____ Document Type: _____ ID Number: _____

Name: _____ Document Type: _____ ID Number: _____

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OTHER COVERAGE IN FORCE OR APPLIED FOR

10. 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?

TOBACCO USE

		PRIMARY	SPOUSE	DEPENDENT 1	DEPENDENT 2	DEPENDENT 3	DEPENDENT 4
11. Within the past six months, have you used tobacco products four or more times per week on average?*	Yes	☐	☐	☐	☐	☐	☐
	No	☐	☐	☐	☐	☐	☐

* This question must be answered for applicants ages 21 and older as of the effective date. Religious or ceremonial use by American Indians or Alaskan Natives is excluded.

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ADDITIONAL NOTES

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AUTHORIZATION

- I have provided true and correct answers to all the questions on this form to the best of my knowledge. My enrollment form information and any amendments shall be the basis for the contract.
- 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. 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 know that my information on this form will only be used to determine eligibility for health insurance and will be kept private as required by law. I know that I must tell Time Insurance Company if anything changes (and is different than) what I wrote on this enrollment form. I can call 1.800.596.0049.
- I agree that a photographic copy of this authorization shall be valid for two years from the date signed.
- I acknowledge receiving the Abbreviated Notice of Insurance Information Practices, the Outline of Coverage for this plan, and the Guide to Health Insurance for People with Medicare, if required.

_____	_____	_____ A.M./P.M.	_____	_____
Signature of Primary	**Date Signed**	**Time Signed**	**City**	**State**

_____

Guardian's Signature

Requested Effective Date: _____ Premium Amount Sent: $_____

FAX ALL PAGES EXCEPT "IMPORTANT NOTICES - MEDICAL" TO 414.299.6020

IMPORTANT NOTICES - MEDICAL

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 false, incomplete or misleading 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 false, incomplete or misleading 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 appropriate regulatory agency in your state.

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.
✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
✓ For help in understanding your health insurance, contact your state insurance department or state insurance program.

LEAVE THIS PAGE WITH THE CUSTOMER - DO NOT FAX

BILLING SELECTION WORKSHEET

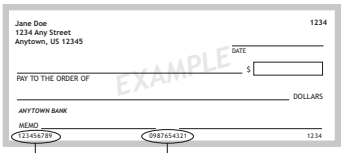
Primary Proposed Insured (PLEASE PRINT): _____
Last Name First Name M.I.

You have four billing options to choose from: Automatic Payment, Credit Card, Direct Bill & List Bill

1. AUTOMATIC PAYMENT

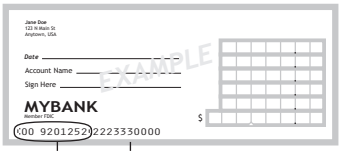
Choose how often: ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

Select Account Type: ☐ Checking



Routing Number *9 digits* Account Number

☐ Savings



Routing Number *9 digits* Account Number

Select a desired withdrawal day 1-28 to coincide with the plan effective date if possible. _____

Bank Name: _____ City: _____ State: _____

Routing Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ Account Number: _____

To add this policy to an existing automatic payment account provide the:

Existing Automatic Payment Account Number:_____ Associated Policy Number: _____

AUTHORIZATION FOR AUTOMATIC PAYMENT — 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: _____

If your billing address is different than your resident address, please enter it here.

Billing Address: _____

Name of person paying, if different:_____

2. CREDIT CARD

Choose how often: ☐ First Payment Only* ☐ Quarterly ☐ Semi-Annual ☐ Annual

*With this option, you must select a secondary billing mode, other than list bill, for subsequent payments.

Select a desired withdrawal day 1-28 to coincide with the plan effective date if possible. _____

AUTHORIZATION FOR CREDIT CARD PAYMENTS — please sign below

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

Card number: _____ _____ _____ _____ - _____ _____ _____ _____ - _____ _____ _____ _____ - _____ _____ _____ _____

Card type: ☐ VISA ☐ MasterCard Expiration date: ____ /____ Name on card: _____

Cardholder billing address if different than resident address: _____

Cardholder signature: _____ Date:_____

3. DIRECT BILL

Choose how often: ☐ Quarterly ☐ Semi-Annual ☐ Annual

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

Billing Address: _____

Name of person paying, if different:_____

4. LIST BILL (*monthly only*) ☐

Assigned account number, if known: _____
Note to agent: this option requires additional list bill forms.