Enrollment Form for Medical Insurance for Individuals and Families

AGENT/AGENCY INFORMATION

Agent Name: _____ Phone Number: _____

Agent Number: _____ E-mail Address: _____

Key Agency Contact: _____ Agency Name: _____

Fax Number: _____ Agency Number: _____

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

☐ **NEW** *If not a new enrollee, check appropriate box and list affected policy number.*

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

- ☐ Internal Replacement
- ☐ Adding Dependent
- ☐ Removal of Tobacco Rates
- ☐ Applying for Preferred Rates
- ☐ Removal of Condition Specific Deductible or Special Exception Rider
- ☐ Removal/Reduction of Special Class Premium
- ☐ 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

	Name *Last*	*First*	*M.I.*	Sex	Age	Birthdate *(MM/DD/YY)*	State of Birth	Height	Weight	Social Security Number
1. PRIMARY										
2. SPOUSE										
3. DEPENDENT(S)	Name *Last*	*First*	*M.I.*	Sex	Age	Birthdate *(MM/DD/YY)*	Full-time Student?	Height	Weight	Social Security Number

4a. Resident Address: _____
(Street) *(City)* *(State)* *(ZIP)*

4b. E-mail Address: _____
By providing your e-mail address you agree that you may receive your policy and/or certificate of issuance and other correspondence electronically.

5. Does any proposed insured live outside the above household? . . . . . ☐ Yes ☐ No

If "Yes," explain. _____

6. Phone Number: (_____) _____ Please list the phone number that would be the best to reach you during the day to inquire about medical history. (_____)_____

7a. **Primary Insured** Occupation: _____

Company Name: _____ Work Number: (_____) _____

Duties: _____

Is the Primary Insured self-employed? ☐ Yes ☐ No

Is the Primary Insured covered by Workers' Compensation? ☐ Yes ☐ No

7b. **Spouse** Occupation: _____

Company Name: _____ Work Number: (_____) _____

Duties: _____

Is the Spouse self-employed? ☐ Yes ☐ No

Is the Spouse covered by Workers' Compensation? ☐ Yes ☐ No

OTHER COVERAGE IN FORCE OR APPLIED FOR

8. 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?

9. Were all proposed insureds covered under the prior plan listed above? ☐ Yes ☐ No
If "No," list those not covered. _____

10. Have any of the proposed insureds ever been declined, postponed, charged an extra premium or had a portion of coverage excluded for life, disability, or medical insurance or had such coverage rescinded? ☐ Yes ☐ No
If "Yes," give details. _____

_____

HAZARDOUS ACTIVITIES AND DRIVING

11. Have any of the proposed insureds ever participated in organized racing including but not limited to, automobile, motorcycle or powerboat racing or any of the following activities: skydiving; ultralight flying; scuba diving; hang gliding; rock or mountain climbing? ☐ Yes ☐ No

If "Yes," indicate:

Who and Which Activity	When/How Often	Do you plan continued participation?
		☐ Yes ☐ No
		☐ Yes ☐ No

12. Have any of the proposed insureds been cited for driving while intoxicated in the past 5 years or had 2 or more moving violations in the past 2 years? ☐ Yes ☐ No
If "Yes," indicate type of violation: _____ Date(s):_____

BILLING

☐ Monthly Check-O-Matic ☐ Quarterly ☐ Semi-Annual ☐ Annual ☐ List Bill *(monthly only)*

Credit Card: ☐ First Payment Only* ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

**With this option, you must select a secondary billing mode other than list bill for subsequent payments. Please make selection above and provide all necessary information.*

If billing address is different than resident address, please complete:

Payor Name | Address | City | State | ZIP

AUTHORIZATION FOR CHECK-O-MATIC BILLING ONLY – *Choose the following option that applies:*

☐ **To begin Check-O-Matic withdrawals:**

Select a desired withdrawal day (1–28): _____

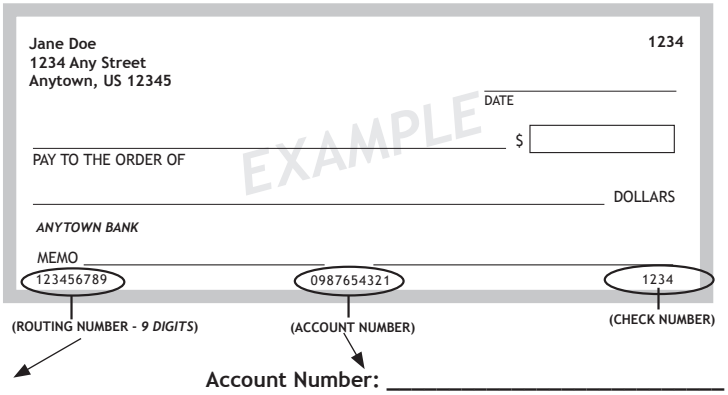
Bank Name: _____

City: _____ State: _____

☐ **To add this policy to an existing Check-O-Matic:**

Existing COM Number: _____

Associated Policy Number: _____



Routing Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Account Number: _____

Check-O-Matic *(Complete authorization below)*

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

Signature of Payor | Date Signed

AUTHORIZATION FOR CREDIT CARD PAYMENTS

When selecting MasterCard/VISA Card: I authorize Time Insurance Company to charge my account for the Individual Medical policy listed above. I understand there will be no refund of premium after the 10-day free look period in the contract.

☐ VISA Card Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

☐ MasterCard Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Exp. Date: _____ / _____

Name as it appears on card: _____

Signature of Payor: _____ Date: _____

Assurant Health 501 West Michigan Milwaukee, WI 53203 Fax 414-299-6020

HEALTH ADVOCATES ALLIANCE MEMBERSHIP APPLICATION

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

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

Member Signature _____ Date _____

HIPAA ELIGIBILITY

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

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

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

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

EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT

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

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

HEALTH STATEMENT

IMPORTANT! PLEASE GIVE COMPLETE DETAILS OF EACH "YES" ANSWER ON THE "ADDITIONAL MEDICAL DETAILS" PAGE.

WITHIN THE LAST 10 YEARS HAS ANY PROPOSED INSURED:

13. HAD ANY DIAGNOSIS OF, RECEIVED TREATMENT FOR, OR CONSULTED WITH A PHYSICIAN CONCERNING:

a) The lungs or respiratory system including but not limited to: hayfever or other allergies; sinus infections; asthma; bronchitis; tuberculosis; pneumonia or emphysema? ..... ☐ Yes ☐ No

b) The heart or circulatory system including but not limited to: high blood pressure; heart attack; heart murmur; chest pain; irregular heartbeat; varicose veins; phlebitis or elevated cholesterol? ☐ Yes ☐ No
If "Yes," please provide last known blood pressure and cholesterol reading on the "Additional Medical Details" page.

c) The digestive system including but not limited to: ulcer; gastritis; heartburn; intestinal disorder; colitis; gallbladder; hemorrhoids; hernia; disorder of the pancreas; spleen; or liver including but not limited to; hepatitis; jaundice or cirrhosis? ..... ☐ Yes ☐ No

d) The nervous system including but not limited to: epilepsy; seizures; unconsciousness; convulsions; vertigo; headaches; paralysis; multiple sclerosis; cerebral palsy; Parkinson's disease; stroke or mini-stroke; TIA or brain attack? ..... ☐ Yes ☐ No

e) Mental disease or nervous disorder including but not limited to: any emotional disorder; anxiety; depression; attention deficit disorder; eating disorder; or psychiatric treatment or counseling?... ☐ Yes ☐ No

f) Congenital disorder, birth defects or developmental disorders including but not limited to Down Syndrome; mental retardation; autism; cleft palate; club foot; or congenital heart defects? ☐ Yes ☐ No

g) The genitourinary system including but not limited to: any kidney disorder; kidney stones; cystitis; prostatitis; bladder infections; or sexually transmitted disease? ..... ☐ Yes ☐ No

h) Diabetes, high or low blood sugar or any disorder of the thyroid gland or other glandular disorder? ☐ Yes ☐ No

i) The muscular, skeletal or connective tissue disorder including but not limited to: arthritis; lupus (SLE); temporomandibular joint disease (TMJ); any back or spine disorder or treatment of any muscular or neuromuscular disorder or any manipulation therapy? ..... ☐ Yes ☐ No

j) Blood or lymph disorders including but not limited to anemia or lymphadenopathy? ..... ☐ Yes ☐ No

k) Cancer? ..... ☐ Yes ☐ No
If "Yes," provide location, type of cancer and treatment received on the "Additional Medical Details" page.

l) Tumor, cyst or growth of any kind; any breast or skin disorders? ..... ☐ Yes ☐ No
If "Yes," provide location, state if treated or removed and date on the "Additional Medical Details" page.

m) Any disorder of the eyes; ears (including ear infections or ear tubes); nose or throat. Tonsils or adenoids; any speech or hearing impairment? ..... ☐ Yes ☐ No

n-1) Any disorder of the reproductive organs, including but not limited to: disorders of the penis; testes; vagina; ovaries and cervix; uterus; diagnosed or treated for infertility or irregular menstruation? ☐ Yes ☐ No

n-2) To the best of your knowledge, are you, your spouse or any dependent now pregnant?..... ☐ Yes ☐ No

n-3) Is any person not named on this enrollment form now pregnant by any person to be insured?..... ☐ Yes ☐ No

IF EITHER N-2 OR N-3 IS ANSWERED "YES," MEDICAL COVERAGE CANNOT BE ISSUED.

QUESTIONS N-4 – N-6 FOR FEMALE APPLICANTS:

n-4) Complications of pregnancy, including but not limited to caesarean section delivery or miscarriage? ..... ☐ Yes ☐ No

n-5) Date of Last Pap Smear: _____ Results: _____

n-6) Have you been instructed to have a repeat Pap Smear or any follow-up treatment or tests as a result of your last Pap Smear? ..... ☐ Yes ☐ No

14. Been diagnosed or treated for AIDS or AIDS-related conditions or tested positive for the presence of HIV antibodies, antigens, or the virus?..... ☐ Yes ☐ No

15. Been diagnosed as having or been treated for any immune deficiency disorder by a member of the medical profession? ..... ☐ Yes ☐ No

16. Experienced any of the following: Signs and symptoms of an immune deficiency disorder may include lymphadenopathy (swollen lymph nodes); loss of appetite; weight loss; chronic fatigue; fever; oral thrush; skin rashes; unexplained infections; dementia; depression; or other psychoneurotic disorders with no known cause?..... ☐ Yes ☐ No

17. Had surgery or has diagnostic testing, treatment or surgery been recommended or scheduled that has not been completed? ..... ☐ Yes ☐ No

HEALTH STATEMENT *CONTINUED*

18. Does any person have any fixation/prosthetic devices present including but not limited to: plates; screws; pins; implants (including breast implants); shunts; pacemakers or valve replacements? ..... ☐ Yes ☐ No
19. Had an electrocardiogram, chest x-ray, or blood test or any other diagnostic testing of any kind or been hospital confined in the past 10 years? ..... ☐ Yes ☐ No
    If "Yes," give name of physician or hospital and results on the "Additional Medical Details" page.
20. Been a member of Alcoholics Anonymous or had any treatment, including but not limited to, counseling for alcoholism or alcohol abuse or been advised by a physician to discontinue or decrease alcohol consumption?..... ☐ Yes ☐ No
21. Used sedatives; tranquilizers; cocaine or other hallucinogenic or narcotic drugs; or received treatment for drug abuse or chemical dependency?..... ☐ Yes ☐ No

ADDITIONAL QUESTIONS

22. To the best of your knowledge, does any person to be insured have any mental or physical impairment, disease or deformity not indicated above? ..... ☐ Yes ☐ No

23a. Have you or your spouse (if to be insured) smoked cigarettes or used tobacco in any form or nicotine substitute within the past year?
PRIMARY INSURED ..... ☐ Yes ☐ No
SPOUSE (if to be insured)..... ☐ Yes ☐ No

23b. Have you or your spouse EVER smoked cigarettes or used tobacco products? ..... ☐ Yes ☐ No
If "Yes," indicate who, amount per day and year quit on the "Additional Medical Details" page.

24. Is any proposed insured currently taking, or taken within the past 12 months, any prescription medication, or receiving medical treatment of any kind? ..... ☐ Yes ☐ No
    If "Yes," provide details of treatment including name and dosage of all medications on the "Additional Medical Details" page.

REQUESTING THE REMOVAL OF A SPECIAL CLASS PREMIUM, SPECIAL EXCEPTION RIDER OR CONDITION SPECIFIC DEDUCTIBLE

25. Has there been any medical treatment or medication use for, or have you consulted with a physician concerning the condition(s) which has had a Condition Specific Deductible, been ridered or rated since the covered person's effective date? ..... ☐ Yes ☐ No
    If "Yes," provide details on the "Additional Medical Details" page.

OTHER PHYSICIANS

26. Regular physician or medical practitioner for each proposed insured. If none, provide last physician seen, date, reason and results.

Primary Proposed Insured's Physician _____
Address _____
Date Last Seen_____ Reason & Results _____
Spouse's Physician_____
Address _____
Date Last Seen_____ Reason & Results _____
Child's Name_____ Physician _____
Address _____
Date Last Seen_____ Reason & Results _____
Child's Name_____ Physician _____
Address _____
Date Last Seen_____ Reason & Results _____
Child's Name_____ Physician _____
Address _____
Date Last Seen_____ Reason & Results _____

ADDITIONAL MEDICAL DETAILS

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

	Provide Dates, Type of Treatment and Results	Name of Doctor or Hospital, and Complete Address and Phone Number
Person: **Condition:** **Question #:**		
Person: **Condition:** **Question #:**		
Person: **Condition:** **Question #:**		
Person: **Condition:** **Question #:**		
Person: **Condition:** **Question #:**		
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Person: **Condition:** **Question #:**		

AUTHORIZATION

I represent to the best of my knowledge and belief, that all statements and answers on this enrollment form are complete and true. The enrollment form and any amendments shall be the basis for the contract. I also agree that:

Except as otherwise provided in the Conditional Receipt, the insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company. The first full premium must be paid. Coverage will become effective on the later of: A) The date we receive the enrollment form; B) The requested Effective Date. 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. The contract may only be effective prior to the contract delivery subject to the terms of the Conditional Receipt.

I agree that a photographic copy of this authorization shall be valid for 30 months from the date signed. You and your authorized representative are entitled to receive a copy of this authorization.

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

We, the undersigned Proposed Insured(s) and agent, acknowledge that the Proposed Insured(s) has read the completed enrollment form. We understand and acknowledge that any fraudulent statement or material misrepresentation or omission on the enrollment form and/or any amendments may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provisions of the contract.

I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, MIB, Inc., consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested to Time Insurance Company, its legal representative or any medical records retrieval service Time Insurance Company may engage, including, but not limited to, 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, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and 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. A copy of this authorization will be valid as an original.

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.

_____
Signature of Primary Proposed Insured

_____
Signature of Spouse or Other *(if proposed to be insured)*

_____
Signature(s) of Other Dependent(s) 18 or Over *(if proposed to be insured)*

_____
Guardian's Signature

Requested Effective Date: _____

Premium Amount Sent: $ _____

One-time Processing Fee Sent*: _____
**Not applicable in all states*

Conditional Receipt Taken: ☐ **Yes** ☐ **No**

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

Attention: (Agent)

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

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

Are you aware of any mental or physical impairment, disease, or deformity of any proposed insured which is not disclosed on the enrollment form? ☐ **Yes** ☐ **No**

If "Yes," please explain. _____

Licensed Resident Agent's Signature

Print Agent's Name

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

ADDITIONAL NOTICES

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.

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 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.

CONDITIONAL RECEIPT

This Conditional Receipt is received from _____ , this _____ day of _____ *(month)* _____ *(year)*.

If full premium is paid and Time Insurance Company accepts this application as applied for within (30) days of the date the application is signed, the effective date will be as specified above, but I agree that I have no insurance coverage under this application until Time Insurance Company notifies me in writing that my application is approved. No agent or broker of the Company is authorized to alter or waive the conditions of this conditional receipt.

For coverage to become effective, each individual to be covered must be a risk acceptable to Time Insurance Company as applied for and at a standard or preferred rate with no Special Exception Riders on the later of: the Requested Effective Date or the Date on which Time Insurance Company receives the application at its home office.

I understand that Time Insurance Company has the right to deny my application and if it does so I will be notified in writing and the premium I submitted will be returned.

If I do not select an effective date, Time Insurance Company will assign an effective date that is later than the date the application is approved.

I must advise Time Insurance Company of any change in information included in the application for me or any person to be insured that occurs after the date I sign the application until the later of the effective date of coverage or the date Time Insurance Company receives the application at its home office. Failure to update Time Insurance Company regarding these changes may result in coverage being voided.