Application Submission Instructions

Please complete the attached application and send to Health Plan One either via fax or mail:

Health Plan One
1000 Bridgeport Ave. 4th FL
Shelton, CT 06484

Fax (Toll Free): 888.342.1612

Any questions? Please call Health Plan One at 1-877.567.5267. Thank you!

ASSURANT
Health

3 Simple Steps with TELE-APP Express Underwriting

1. Complete the **Eligibility Review** forms with your Individual Medical customer. If a person to be insured answers "yes" to any of the questions on the Eligibility Review forms, do not proceed to Step 2 with that applicant.
2. Complete Part 1 with your customer. If your customer is paying by Check-O-Matic, Credit Card or List Bill, immediately fax pages 1, 2, 3 and 4 of part 1 and the Software Proposal to **414-299-6020**. Be sure you and your customer sign the Conditional Receipt before you tear it off and leave it with them.
3. Prepare your customer for their Personal Health History Interview by giving them the **Personal Health History Interview Applicant Instructions**. Applicants must call for their interview within 10 days to ensure the Conditional Receipt is valid.

Check it out – then check it off!

Use this easy checklist to make sure you're not missing anything for ***TELE-APP***.

- ☐ Are other underwriting forms required? Send them along with Part 1 and the Software Proposal.
- ☐ If your customer *must* pay with a mode other then COM or Credit Card, make sure you mail that payment with Part 1 to ensure the Conditional Receipt is valid. Mail to P.O. Box 2962, Milwaukee, WI, 53201-2962.
- ☐ One applicant needs to call in for the interview. Help your customers choose who's best equipped to represent him/herself and all others applying for coverage. Here are some common scenarios to help your customers decide who should participate in the interview:
- ☐ Entire family applying:
  - If both the adult primary insured and spouse are applying for coverage, either can provide the history for the entire family.
- ☐ One parent and dependent child(ren) applying:
  - The parent on the application can provide the history for all applicants.
  - A non-applicant parent CAN provide the history for the dependent child(ren).
  - A non-applicant parent CANNOT provide the history for an applicant parent.
- ☐ Child(ren) only applicants:
  - Either the parent or legal guardian must provide the history.
  - Children, if over 18 and applying for their own policy, must provide their own health history.
- ☐ Multiple policy applicants (including KeyMed): If multiple policies are being applied for by different family members, an adult applicant on each policy will be required to complete the interview, except for child only applicants.
- ☐ During the interview, your customer will speak directly with an Assurant Health underwriting representative. Have them ready to review their medical history for the past 5 years for everyone who's applying.
- ☐ Provide your customer with the Applicant Instructions and direct them to call **800-596-0049** to begin the express underwriting process.

Eligibility Review for Standard Portfolio Plans

Complete the questions below. If any person to be insured answers yes to any of these questions, the applicant(s) will not be eligible to continue*. You can continue the process with other applicant(s) who have not answered yes.

**** The applicant(s) that is not eligible for Standard Portfolio Plans should complete the Eligibility Review for KeyMed on the following page.***

1. **Will any person to be insured become eligible for any other form of medical insurance in the next six months?** ..... Yes ☐ No ☐
2. **Is anyone in your household currently pregnant, an expectant parent or in process of adoption or surrogate pregnancy?** ..... Yes ☐ No ☐
3. **Is any person to be insured NOT a U.S. citizen or Lawful Permanent Resident/Green Card Holder?** ..... Yes ☐ No ☐
4. **Does any person to be insured have or ever had any of the ineligible medical conditions?** ..... Yes ☐ No ☐
   Refer to the Underwriting Field Guide on Find A Form on the Assurant Health Agent Information site at www.assuranthealthsales.com
5. **Is any person to be insured employed in an ineligible occupation?** ..... Yes ☐ No ☐
6. **Is any person to be insured over the acceptable height/weight limits in the ineligible build table?** ..... Yes ☐ No ☐

Unisex Height / Weight - 16 years and over			
Height	Max. for Rating	Height	Max. for Rating
4'10"	190	5'10"	277
4'11"	197	5'11"	285
5'0"	203	6'0"	293
5'1"	210	6'1"	301
5'2"	217	6'2"	310
5'3"	224	6'3"	318
5'4"	231	6'4"	327
5'5"	239	6'5"	336
5'6"	246	6'6"	345
5'7"	254	6'7"	354
5'8"	261	6'8"	363
5'9"	269		

Ineligible Occupation List

Applicants recently laid off, temporarily unemployed or between jobs, or on medical disability are not eligible

Adult Entertainers/Dancers
Air traffic controllers
Armed Forces personnel
Asbestos/toxic chemical workers
Boxers and prize fighters
Circus, carnival and amusement park performers/workers
Commercial Fisherman/Crew going on overnight excursions
Divers (professional skin or scuba and ocean rescue and recovery)
Explosive workers
Oil and natural gas workers both on-shore and off-shore operations
Professional motor vehicle racers
Professional athletes including but not limited to: ballet, baseball, basketball, football, wrestling
Professional crop dusters
Structural steel workers
Stunt flyers/Stunt person
Underground miners
Unemployed due to disability

Eligibility Review for KeyMed

Complete the questions below if you are applying for the KeyMed plan. If the client responds YES to any of the questions, below, they are not eligible for the KeyMed Plan. You can continue the process with other applicants who have not answered yes.

1. Is anyone in your household currently pregnant, an expectant parent or in process of adoption or surrogate pregnancy? ..... Yes ☐ No ☐
2. Is any person to be insured NOT a U.S. citizen or Lawful Permanent Resident/Green Card Holder? ..... Yes ☐ No ☐
3. Does any person to be insured have or ever had any of the ineligible medical conditions? ..... Yes ☐ No ☐
   Refer to the **Underwriting Field Guide - for KeyMed Use Only** on Find A Form on the Assurant Health Agent Information site at www.assuranthealthsales.com
4. Is any person to be insured employed in an ineligible occupation (see below)? ..... Yes ☐ No ☐
5. Is any person to be insured over the acceptable height/weight limits in the ineligible build table? ..... Yes ☐ No ☐

KeyMed Unisex Height / Weight – 16 years and over

Height	Max. for Rating	Height	Max. for Rating
4'10"	209	5'10"	305
4'11"	216	5'11"	314
5'0"	224	6'0"	323
5'1"	231	6'1"	332
5'2"	239	6'2"	341
5'3"	247	6'3"	350
5'4"	255	6'4"	360
5'5"	263	6'5"	370
5'6"	271	6'6"	380
5'7"	279	6'7"	390
5'8"	288	6'8"	400
5'9"	296		

Ineligible Occupation List

Applicants recently laid off, temporarily unemployed or between jobs, or on medical disability are not eligible

Adult Entertainers/Dancers
Air traffic controllers
Armed Forces personnel
Asbestos/toxic chemical workers
Boxers and prize fighters
Circus, carnival and amusement park performers/workers
Commercial Fisherman/Crew going on overnight excursions
Divers (professional skin or scuba and ocean rescue and recovery)
Explosive workers
Oil and natural gas workers both on-shore and off-shore operations
Professional motor vehicle racers
Professional athletes including but not limited to: ballet, baseball, basketball, football, wrestling
Professional crop dusters
Structural steel workers
Stunt flyers/Stunt person
Underground miners
Unemployed due to disability

Agent Name: _____ Agent Phone Number: _____

Personal Health History Interview Applicant Instructions

Thank you for your interest in our individual medical insurance. In addition to the Part 1 you completed with your agent, this Personal Health History Interview (PHHI) will help us determine eligibility for health insurance. One of our underwriting representatives will conduct your interview.

Just follow these steps for a quick and accurate interview:

☐ This series of questions will help you prepare for your PHHI. Be prepared to **provide current height and weight** for everyone applying for coverage in addition to answering the following questions. If you answer "yes" to any of these questions, be prepared to provide: Date the condition began, name and address of treating physician, type and date of treatment received.

- Had surgery in a hospital or outpatient facility?
- Had medical treatment in a hospital or outpatient facility?
- Had any urgent care or emergency room visits?
- Received treatment, testing, consulted with or received a diagnosis from a physician or healthcare provider? Do NOT include annual physical exams.
- Had any testing with abnormal findings or tests for which you have not received results?
- Been recommended or scheduled for diagnostic testing, consultations, treatment, follow-up or surgery that has not been completed?
- Received or recommended to have any treatment for alcoholism, alcohol or drug abuse or addiction, including but not limited to, counseling or attendance at support groups?
- Used illegal drugs or prescription medication other than as prescribed or been advised by a physician or health care provider to discontinue or decrease alcohol consumption or drug use?
- In the last 5 years, have any of the proposed insureds participated in any motorized vehicle racing (includes drivers, pit crew, owners or mechanics) or any of the following activities: skydiving, ultralight flying, scuba diving, hang gliding, rock or mountain climbing or rodeo participation?
- In the last 5 years, have any of the proposed insureds been cited for operating a motor vehicle under the influence of alcohol or drugs?
- Has any proposed insured taken or been advised to take any prescription medication in the last 12 months?
- Has any proposed adult insured used tobacco products in any form or nicotine substitutes within the last year?
- Has any proposed insured had a diagnosis, treatment or follow-up for cancer in the last 10 years?
- Is any proposed insured currently pregnant, an expectant parent or in the process of adoption or surrogate pregnancy?
- Have you fully disclosed all medical conditions, for you and your family within the last 5 years?
- Have any of the proposed insureds been declined, postponed, rescinded, reformed, charged an extra premium or had a portion of coverage excluded for life, disability, or medical insurance?

(continued)

Choosing the adult for the interview.

- ☐ The adult calling our office should be familiar with the health history of **ALL** family members applying for coverage and be able to provide details to the questions on the previous page.
- ☐ Please review the following common scenarios to help you decide which member of your family is best equipped to participate in the interview. Based on your situation and insurance needs, choose one adult, who's applying for coverage, to contact Assurant Health.
- ☐ Entire Family applying
  - If both the adults are applying for coverage, either can provide the history for the entire family.
- ☐ One parent and dependent child(ren) applying
  - The parent on the application can provide the history for the entire family.
  - A parent not applying for coverage CAN provide the history for the dependent child(ren).
  - A parent NOT applying for coverage CANNOT provide the history for a parent applying for coverage.
- ☐ Child(ren) only applicants
  - Either the parent or legal guardian must provide the history.
  - Children, if over 18 and applying for their own policy, must provide their own health history.
- ☐ If your family is applying for multiple policies (including KeyMed), an adult applicant for **each** policy will be required to complete the interview, except for child only applicants.

Calling our Office

- ☐ **Call within 10 days of completing the enrollment form with your agent.** This allows the terms of your Conditional Receipt to be honored.
- ☐ **Allow 15 minutes for the call**. Interview time may vary based on the number of people applying for coverage and the extent of their medical conditions.
- ☐ **Dial 800-596-0049** to conduct your interview.
- ☐ **Your agent will contact you** following the interview. Eligible applicants will be asked to attest to the interview information in writing upon receipt of your contract.

Please keep this form for your reference.

Tele-App Part 1 Enrollment Form for Medical Insurance for Individuals and Families

PLEASE PRINT IN BLACK INK

AGENT/AGENCY INFORMATION

Agent Name: William Stapleton

Agent Number: 000493CH100001

Key Agency Contact: _____

Fax Number: 888-342-1612

Phone Number: 877-567-5267

E-mail Address: sales@healthplanone.com

Agency Name: HEALTH PLAN ONE

Agency Number: 000493CH100001

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 ☐ Conversion (over age dependent/divorce)

PERSON(S) TO BE INSURED

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

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 any type of medical insurance? ☐ Yes (Complete section below)
☐ No

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?

REMEMBER TO FAX PAGES 1, 2, 3 & 4 AND THE SOFTWARE PROPOSAL TO 414-299-6020

7b. 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

7c. Spouse Occupation: _____

Company Name: _____ Work Number: (_____) _____

Duties: _____

Is the Spouse self-employed? . . . . . ☐ Yes ☐ No

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

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 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): _____

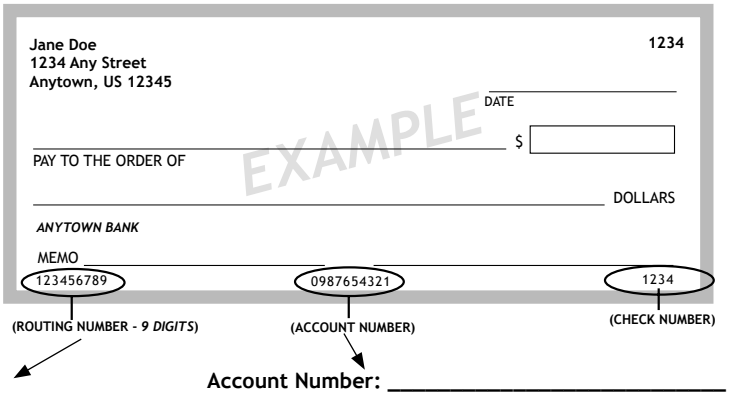
Bank Name: _____

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 Assurant Health 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: _____

REMEMBER TO FAX PAGES 1, 2, 3 & 4 AND THE SOFTWARE PROPOSAL TO 414-299-6020

COMPLETE IF REQUESTING LIFE INSURANCE COVERAGE

Beneficiary for Primary Insured: _____

(Full Name) *(Relationship)*

Contingent Beneficiary: _____

(Full Name) *(Relationship)*

The Primary Insured is the beneficiary of any Spouse or Child(ren) Life Insurance.

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 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 (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 following 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 one or more of the foregoing requirements.**

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

REMEMBER TO FAX PAGES 1, 2, 3 & 4 AND THE SOFTWARE PROPOSAL TO 414-299-6020

EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT

You understand and agree that you are applying for group non-employment related 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

AUTHORIZATION

In order to determine my (our) eligibility for insurance, I authorize any licensed physician, medical practitioner, hospital, clinic, any pharmacy, pharmacy benefit manager or pharmacy-related entity, any medically-related facility, insurance company, the Medical Information Bureau, employer, or consumer-reporting agency to give Time Insurance Company (or any consumer-reporting agency authorized by Time Insurance Company) any information regarding me or my family as to employment, other insurance coverage, personal information, and medical or pharmacy care, advice or treatment, or medication use.

I represent to the best of my knowledge and belief, that all statements and answers on Part 1 are complete and true. My recorded Personal Health History, Part 1 and any amendments shall be the basis for the contract. I also agree that: (1) Within 30 days of policy delivery, I must formally accept the offer by verifying the accuracy of the enrollment form information with a signature and returning that signed acceptance to Time Insurance Company. (2) 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 and accepted by me. (3) I understand and agree that any information I provide through this application process may be shared with persons necessary to facilitate issuing coverage, including but not limited to my agent or broker. (4) If any of these conditions are not met, Time Insurance Company has the right to rescind its offer of coverage and the full extent of its liability shall be limited to the sum received.

I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, the Medical Information Bureau, 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.

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, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs. This information may also be disclosed to 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: denial of my application, declination of enrollment, or, if insured 30 months from date of signature or, when I am no longer an insured of Time Insurance Company.

Signature of Primary Proposed Insured	Signature of Spouse or Other Insured (if proposed to be insured)
(Circle one) A.M. / P.M.	
Date Signed / Time Signed	City & State
Conditional Receipt Given? ❑ Yes ❑ No	Requested Policy Effective Date

REMEMBER TO FAX PAGES 1, 2, 3 & 4 AND THE SOFTWARE PROPOSAL TO 414-299-6020

ADDITIONAL NOTICES

NOTIFICATION REGARDING 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 MIB, 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 in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

Time Insurance Company, or its reinsurers, may also release information in 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.

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.

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 the Personal Health History call is completed.

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 on which the Personal Health History call is completed. Failure to update Time Insurance Company regarding these changes may result in coverage being voided.

LEAVE THIS PAGE WITH THE CUSTOMER – DO NOT FAX