ASSURANT Health®

PENNSYLVANIA

Assurant® Health Access℠
In Force Underwriting Change Packet

Thank you for trusting Assurant Health to insure your clients. We appreciate your business! To quickly and easily submit your in force underwriting change request, please follow these simple steps.

To add a spouse or dependent, to request reinstatement of coverage or to request a plan upgrade:

1. Fully complete the enrollment form included in this packet, including:
    - All required questions
    - All required signatures
    - "ARE YOU AN EXISTING CUSTOMER?" section of the enrollment form, which indicates the type of change being requested
2. Send the completed enrollment form to Assurant Health In Force Underwriting by fax or mail.
    - Fax: 414.299.8811
    - Mail:
      Assurant Health
      PO Box 551
      Milwaukee, WI 53201-0551
3. Please do not submit any payment with the enrollment form. Processing fees are waived for in force changes, reinstatements and guaranteed conversions. If the request is approved, we will adjust premiums and send a notice. You can find the applicable rate in FORM 49912-PA, available at assuranthealthsales.com.

To request a conversion (over-age dependent or divorce):

1. You do not need to complete the health statement questions. Complete the enrollment form included in this packet, including:
    - All required signatures
    - "ARE YOU AN EXISTING CUSTOMER?" section
2. Send the completed enrollment form to Assurant Health New Business Underwriting by fax or mail.
    - Fax: 414.299.6020
    - Mail:
      Assurant Health
      PO Box 624
      Milwaukee, WI 53201-0624

If you have questions regarding your change request, please refer to the "Plan Changes" section of the *Agent Guide for Assurant Health Access* or call 800.800.1212.

Please note that no benefits will be provided for any medical events that occur between the date this enrollment form is signed and the effective date of the plan change. 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.

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.

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

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

5. Phone Number: (___) _____

6. E-mail Address: _____

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

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 1st through the 15th of the month, your effective date will be the 1st of the following month. If you sign the enrollment form on the 16th through the 31st of the month, your effective date will be the 15th of the following month. Check with your agent for more details.

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

Time Insurance Company
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.
9. 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?	Yes	☐	☐	☐	☐	☐	☐
	No	☐	☐	☐	☐	☐	☐
10. Are you, your spouse or any person to be insured totally and permanently disabled and/or receiving long-term disability benefits?	Yes	☐	☐	☐	☐	☐	☐
	No	☐	☐	☐	☐	☐	☐
11. 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:	Yes	☐	☐	☐	☐	☐	☐
	No	☐	☐	☐	☐	☐	☐

- Heart disorder, excluding Mitral Valve Prolapse (MVP) or surgically corrected or closed Atrial Septal Defect (ASD)/ Ventricular Septal Defect (VSD)
- Stroke or Brain Aneurysm
- Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
- Crohn's Disease or Ulcerative Colitis
- Liver disorders, excluding fully recovered Hepatitis A
- Kidney disorders, excluding kidney stones
- Emphysema, Chronic Obstructive Pulmonary Disease (COPD), Fibrotic Lung Disease or Primary Pulmonary Hypertension
- Diabetes, excluding Gestational Diabetes
- Basal Cell Carcinoma with recommended surgery that has not been completed
- Cancer or Tumor
- Alcoholism, Alcohol or Chemical Dependency or Drug or Alcohol Abuse
- Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV)
- Multiple Sclerosis (MS)
- Tuberculosis (TB)
- Any condition that resulted in a surgery or procedure whose purpose is to promote weight-loss
- Autism Spectrum Disorders, Autism, Asperger's Disorder, Rett's Syndrome, Pervasive Developmental Disorders or Pervasive Developmental Delay

Time Insurance Company
501 West Michigan
Milwaukee, WI 53203

BILLING

You have four billing methods to choose from:

1. Monthly payroll deduction (list bill)

You have four choices for billing. It's important to note we'll request funds as soon as we issue your policy.

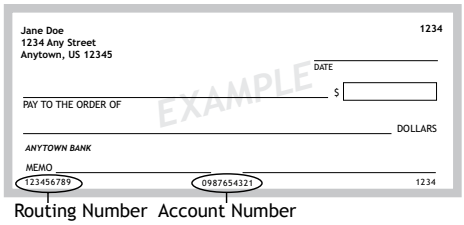
➜ Assigned list bill number, if known: _____
Note to agent: This option requires the employer have a list bill agreement on file.

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

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

➜ 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: _____

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

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

You have two options if choosing to pay by credit card — recurring or 1st payment only.

➜ 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

The cardholder's signature is needed here if requesting to pay by credit card.

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

Please complete this if your billing address is different than your home address.

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:_____

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

Time Insurance Company
501 West Michigan
Milwaukee, WI 53203

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 all programs offered or sponsored by the Association. 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 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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Time Insurance Company
501 West Michigan
Milwaukee, WI 53203

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., 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, 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 24 months from the date signed.

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

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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 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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Time Insurance Company
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

You don't need to do anything here. Your agent will complete this section.

Agent Name: _____

Agent Number: _____

Key Agency Contact: _____

Fax Number: _____

Phone Number: _____

E-mail Address: _____

Agency Name: _____

Agency Number: _____

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Time Insurance Company
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.

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

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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