Assurant SHORT-TERM Health Insurance Coverage INSTRUCTIONS

******* California Only *******

Thank you for requesting more information on the Assurant PPO $2 Million Dollar Short-Term Health Insurance Policy!
If you live in California, the following carriers have stopped offering short-term coverage until further notice:

- Anthem Blue Cross
- Blue Shield of CA
- Health Net
- And many more!

Your deductible of choice is shared by ALL family members (if there is more than one person on the policy). **Your effective date can be as soon as midnight, the same day you apply**. Click on the Assurant logo on our website to figure out which plan is best for your unique situation.

STEP 1: CALCULATE MONTHLY PREMIUM
By clicking on the Assurant logo below or on our website, you can calculate your premium:

ASSURANT Health

STEP 2: ADD $25 – IT IS A (1) TIME ENROLLMENT FEE
There is a one-time application fee that you will be charged. It is $25 whether there is one applicant or multiple family members on the same application.

STEP 3: SEARCH FOR YOUR DOCTOR OR HOSPITAL
By clicking on the PHCS logo on our website, you can search for doctors and hospitals in the Private Health Care Systems network:

PHCS

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4 deductibles to choose from (shared by all family members):

- $1,000
- $2,500
- $3,500
- $5,000

There are 3 levels of co-insurance %:

(Assurant / You)
50% / 50%
80% / 20%
100% / 0%

HOW TO APPLY:

If you already know which plan is best for your situation, then go to the website and print the **"STM Application"**

1) Print out the 2 page application (pages 11 & 12 of the brochure or pages 2 & 3 of the application)
2) Complete, sign and date
3) Be sure to add the $25 (1) time enrollment fee for the 1st months premium
4) Scan it back in and email it to marc@nocobra.com or Fax it to (949) 713-7278 [24 hours/day].
   Snail Mail: NoCobra.com, Inc 27 Lazurite, Suite #100 Rancho Santa Margarita, CA 92688

If you have any questions, feel free to call or email anytime! Thank you for your business.

Marc L. Harris
Rancho Santa Margarita, CA
Direct Line: (949) 713-7222
Fax: (949) 713-7278
email: marc@nocobra.com

Best Value!
$3,500 Deductible
50% / 50% co-insurance

Visit Our Website!

NO COBRA .COM

Dental Insurance under..... $6/month!
Vision Insurance for ONLY.....$4/month!

**** IF YOU ARE IN A STATE OTHER THAN CALIFORNIA, THEN CLICK THIS LINK:**

Individual and Family Health Insurance
Get a FREE quote now!

Short Term Medical Enrollment Form Time Insurance Company **CALIFORNIA**

Requested Effective Date			Certificate/Policy Number
Month	Day	Year	

Applicant's Name (print last, first, middle)	Gender	Birth Date	Social Security Number

Street Address	City, State, ZIP Code

Spouse's/Domestic Partner's Name (if to be insured)	Gender	Birth Date	Social Security Number

Children (Name) (if to be insured)	Birth Date	Name	Birth Date	Name	Birth Date
1.		2.		3.	

Note: Under no circumstances can coverage become effective prior to the date this application is signed.

California law prohibits an HIV test from being required or used by health care plans as a condition of obtaining coverage.

Answer the following questions completely and accurately.

		Primary	Spouse	Child 1	Child 2	Child 3
1. Have/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? ◆ over 300 pounds if male, or over 250 pounds if female?	Yes	☐	☐	☐	☐	☐
	No	☐	☐	☐	☐	☐
	Not Sure	☐	☐	☐	☐	☐
2. In the past 15 days have you or any person to be insured: been seen by a healthcare professional for any reason other than a routine checkup or been admitted to a hospital?	Yes	☐	☐	☐	☐	☐
	No	☐	☐	☐	☐	☐
	Not Sure	☐	☐	☐	☐	☐
3. In the past 12 months, have you or any person to be insured: been recommended to have or been scheduled for diagnostic testing, treatment or surgery that has not been completed?	Yes	☐	☐	☐	☐	☐
	No	☐	☐	☐	☐	☐
	Not Sure	☐	☐	☐	☐	☐
4. 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: ◆ heart disorder? ◆ emphysema, Chronic Obstructive Pulmonary Disease (COPD)? ◆ Crohn's disease, ulcerative colitis or hepatitis (B or C)? ◆ AIDS/ARC excluding abnormal test results for HIV status? ◆ stroke? ◆ diabetes, except Gestational Diabetes? ◆ cancer or tumor except Basal Cell Skin Cancer which has been removed? ◆ alcoholism, chemical dependency, drug or alcohol abuse? ◆ Pervasive Developmental Disorders, Autism Spectrum Disorder, Autism, Asperger's Disorder?	Yes	☐	☐	☐	☐	☐
	No	☐	☐	☐	☐	☐
	Not Sure	☐	☐	☐	☐	☐

Deductible Amount	Payment Option and Length of Coverage	Coinsurance	Total
☐ $ 2,500 ☐ $ 3,500 ☐ $ 5,000	☐ Single Payment — Total number of days needed _____ ☐ Monthly Payment — Coverage is needed for: up to 6 months (30-180 days)	☐ 80% ☐ 50%	

OPTIONAL RIDER (Additional premium required) I hereby select this/these benefit(s):
~~☐ Accident Medical Expense~~ ~~☐ Dental-Vision Discount Plan~~

Please provide the **name**, **address**, **phone number** and **policy number** for each health insurance policy you had during the previous 12 months.

Name	Address	Telephone Number	Policy Number

The undersigned attests that the information above is true to the best of his/her knowledge. The undersigned realizes that any false, or inaccurate statement or misrepresentation in the enrollment form may result in claim denial or contract rescission. Any person who injures, defrauds, or deceives any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. Where the undersigned is 19 years or older, the undersigned understands that the plan applied for will not pay benefits for any expenses incurred on account of a pre-exisiting medical condition.

If I am self employed or an employee of an employer with 50 or fewer employees, I warrant premiums for this coverage are not: (1) Paid or reimbursed by my employer or, (2) To the best of my knowledge, treated as tax-deductible by my employer or me as related to an employer benefit plan (internal Revenue Code sections 106,125,162 or 213).

Primary Physician's Name (if any)	Primary Physician's Telephone Number
X **Applicant's Signature**	**Today's Date**
Day Telephone Number	Evening Telephone Number

Agent Attestation (To be completed only by the Agent)

Check the box that indicates your participation.

☐ I did assist the applicant in the application process

As an agent or broker who assisted an applicant in submitting an application to Time Insurance Company, I am attesting that to the best of my knowledge, the information on the application is complete and accurate. I further attest that I have explained to the applicant, in easy to understand language, the risk to the applicant of providing inaccurate information and that the applicant understood the explanation.

I understand that if I, as the agent, willfully state as true any material fact that I know to be false, I will, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to $10,000. Any public prosecutor may bring a civil action to impose that penalty. These penalties will be paid to the Insurance Fund.

X ☒ I did not assist the applicant in the application process

Agent's Signature	Marc L. Harris / NoCobra.com, Inc. Agent's Name	
000676ED000001 Agent's Number	Date Completed	Today's Date

Form 28786.CA (Rev. 12/2010)

Electronic Policy Option

I would like to receive my policy and the company's "Notice of Privacy Practice" via the Internet..... ☐ **Yes** ☐ **No** **To receive policy delivery via the Internet, you must provide your email address in the space to the right.** ➡	Email Address

Payment Information

Step 1: Select a Method of Payment:

☐ MasterCard ☐ Visa ☐ Check Automatic charge: ☐ Checking ☐ Savings account *(Only available with the Monthly Payment Option)*

When submitting via paper application, please submit first month premium via check along with a separate voided check

Bank Routing Number:_____ Account Number:_____

▼ Enter your Credit Card information here ▼

Card # ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ Exp. Date: _____ /_____

Authorized Amount $ _____ (Insert Initial Premium Payment Amount)

Important Reminders: The application fee is non-refundable. There will be no refund of premium after the 10-day free look period in the contract.

Step 2: Authorization

- **When selecting the single payment option with MasterCard/Visa:** I authorize Assurant Health to charge my account for the Short Term Medical policy listed above.
- **When selecting the monthly payment option with MasterCard/Visa or Automatic Charge to a checking or savings account:** I authorize Assurant Health to charge my account each month for the Short Term Medical policy listed above, until the end of the policy or until I request cancellation in writing. I understand I can request the charge be stopped if I notify Assurant Health seven days in advance of the charge occurring.

X **Account Holder's Signature**	**Date**	App Source
Agent Name Marc L. Harris / NoCobra.com, Inc.	Agent ID# 000676ED000001	Confirmation Code (home office use only)