APPLICATION FOR MEDICAL INSURANCE

PLEASE PRINT IN BLACK INK

AGENT INFORMATION

Agency Name and Time Number GA: Group Warehouse Ins. - CJ Johnson 17085 - 000493BV000001

Agent Name and Time Number _____ Phone # _____

Agent Fax Number _____ General Agent is located in the state of Texas

TYPE OF ACTIVITY check appropriate box

❑ **New Applicant**

❑ **Change to an existing policy. Policy #** _____

❑ **Upgrading Coverage**
Existing Policy # _____

- ❑ Adding Dependent
- ❑ Reinstatement of Coverage
- ❑ Applying for removal of special exception rider
- ❑ Applying for removal/reduction of special class premium
- ❑ Other _____

PERSON(S) TO BE INSURED

Name: Last / First / M.I.	Sex	Age	Birthdate Mo/Day/Yr	State of Birth	Height	Weight	Social Security #	Tobacco User Refer to p. 4, #27
1. (Primary)								❑ Yes ❑ No
2. (Spouse)								❑ Yes ❑ No

3. DEPENDENT'S NAME Last / First / M.I.	Relationship	Sex	Age	Full Time Student Yes	Full Time Student No	Birthdate Mo/ Day /Yr	Height	Weight	Social Security #

4. Resident Address

_____
STREET CITY STATE ZIP

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

If yes, explain _____
(IN CASE OF A MINOR, CUSTODIAL PARENTS SIGNATURE WILL BE REQUIRED TO ATTEST TO MEDICAL HISTORY)

6. Home Phone Number _____ Best time to call _____
AREA CODE NUMBER

7a. Occupation (Primary): _____ ❑ Full-Time ❑ Part-time Hours worked per week _____

Company Name: _____ Work Phone Number: _____

Duties: _____

Self Employed: ❑ Yes ❑ No Covered by Worker's Compensation: ❑ Yes ❑ No

7b. Occupation (Spouse): _____ ❑ Full-Time ❑ Part-time Hours worked per week _____

Company Name: _____ Work Phone Number: _____

Duties: _____

Self Employed: ❑ Yes ❑ No Covered by Worker's Compensation: ❑ Yes ❑ No

IF REQUESTING LIFE INSURANCE COVERAGE

8. 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.)

Form 26683 (Rev. 10/2004) **Time Insurance Company** 501 West Michigan Milwaukee, WI 53203 8/2005

ASSURANT Health

Underwriting Authorization

*** IMPORTANT ***

HIPAA Regulation: Please have your client sign this form along with the completed application/enrollment form. If we do not receive this signed form, the underwriting process could be delayed.

Name of Proposed Insured(s): _____

_____

Address: _____

_____

_____

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 Assurant Health, its legal representative or any medical records retrieval service Assurant Health 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, lab data and EKGs. This information may also be disclosed to any medical records company engaged by Assurant Health, 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 Assurant Health 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 Assurant Health to make eligibility or enrollment determinations relating to me and/or my minor children or for Assurant Health's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, Assurant Health may refuse to consider my application for enrollment.

I understand that I may revoke this authorization at any time by notifying Assurant Health in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Assurant Health, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if Assurant Health 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, when I am no longer an insured of Assurant Health.

_____

Signature of Primary Proposed Insured or representative*

_____

Date

_____

Signature of Spouse or Other Proposed Insured(s) or representative*

_____

Date

_____

Signature of Other Dependents 18 or over (if proposed to be insured)

_____

Date

*If you are the individual's representative and are not the parent or legal guardian of a minor, you must attach documentary evidence of your authority to act as the individual's representative for this authorization to be valid.

PLEASE RETAIN A COPY FOR YOUR RECORDS

FAIR CREDIT REPORTING ACT AND PRIVACY ACT PRE-NOTIFICATION

Thank you for considering Time Insurance Company as your insurance carrier. Your application will be processed as quickly as possible. Public Law 91-508 and state privacy acts require that we advise you that an investigative consumer report may be made in connection with this application which will provide applicable information concerning character and general reputation. The information for this report may be obtained through telephone or personal interviews with you, your friends, neighbors and associates. You may request an interview in connection with the preparation of the report. Upon written request, you are entitled to receive a copy of the report.

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 the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request form from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. Time Insurance Company or its reinsurers may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may also apply for life, disability or medical insurance, or to whom a claim for benefits may be submitted.

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

Information collected by us and used to issue an insurance policy or certificate may 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.

Time Insurance Company Authorization for Check-O-Matic Billing

Choose the following option that applies:

- ❑ To begin Check-O-Matic withdrawals
- ❑ To add this policy to an existing Check-O-Matic account with Time Insurance Company.
  Note: Please provide the existing Check-O-Matic number and/or associated policy number.

  Existing COM Number_____

  Associated Policy Number_____

Desired withdrawal day: (1-28)_____
Note: We recommend a withdrawal date equal to or within 5 days of your policy issue day.

ACCOUNT INFORMATION: Complete only if different than information on check:

PAYOR'S BILLING ADDRESS

Payor's Name _____

Address _____

City_____ State_____ ZIP_____

I (we) hereby authorize Time Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account indicated below and the depository named below, herein after called DEPOSITORY, to debit the same to such account.

This authority is to remain in full force and effect until COMPANY and DEPOSITORY has 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.

X_____ X_____

(Signature of Payor) (Date Signed)

PLEASE ATTACH VOIDED CHECK.

(NO DEPOSIT SLIPS PLEASE)

CONDITIONAL RECEIPT

Received from: _____, this _____ day of _____, _____.

The sum of $_____ in connection with the application for Medical Insurance with Time Insurance Company.

No insurance will become effective prior to contract delivery. Except, insurance may become effective prior to the contract delivery if and when each and every condition contained in this receipt is met. No agent or broker of the Company is authorized to alter or waive any of the following conditions:

The conditions under which insurance may become effective prior to contract delivery are as follows:

1. The Proposed Insured(s) must be, on the Effective Date, as hereafter defined, a risk acceptable to the Company under its rules, standards and practices for the exact contract and premium applied for, without any modification.
2. The amount of the payment taken with the application must be equal to the amount of the full first premium payment selected.
3. The contract is issued exactly as applied for within 60 days from the date of the application. If the contract is not issued within 60 days from the date of application, there will be no coverage provided under the terms of this Conditional Receipt. Any coverage provided by the Conditional Receipt ends when the contract is delivered.
4. Proposed Insured(s) agree to complete the medical information report as part of the application process.

If each of the above conditions are fulfilled, then the insurance as provided by the terms and conditions of the contract applied for will become effective on the Effective Date prior to the contract delivery.

"Effective Date" as used herein means the later of: a) the date the application is signed; and b) the requested Effective Date.

If one or more of the conditions are not met, the liability of the Company will be limited to the return of the sum received.

_____ _____

AGENT'S SIGNATURE PROPOSED INSURED'S SIGNATURE

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY — DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK

I represent to the best of my knowledge and belief, that all statements and answers on this application form are complete and true. The application 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 of the application; B) The requested Effective Date. A change in the health of the proposed insured(s) after the completion of the application 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.

In order to determine my (our) eligibility for insurance, I authorize any licensed physician; medical practitioner; hospital; clinic; any medically related facility; insurance company; the Medical Information Bureau; employer; or consumer reporting agency to give to Time Insurance Company (or to 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 care, advice or treatment.

I agree that a photographic copy of this authorization shall be valid for two years from the date signed.

I acknowledge receiving the Fair Credit Reporting Act Pre-Notification, the notification regarding the Medical Information Bureau, 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 application. We understand and acknowledge that any fraudulent statement or material misrepresentation on the application 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.

_____
Signature of Primary Proposed Insured

_____
Signature of Spouse or Other Insured
(If proposed to be insured)

_____
Signature(s) of Other Dependents 18 or Over
(If proposed to be insured)

_____
Guardian's Signature

Requested Effective Date _____

Premium Amount Sent $ _____

One Time Processing Fee Sent $ 20.00
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 application 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.

Are you aware of any mental or physical impairment, disease or deformity of any proposed insured which is not disclosed on this application? ❑ Yes ❑ No

If yes, please explain_____

_____

_____
Licensed Resident Agent's Signature

_____
Print Agent Name & Agent Number or Business Number

_____ Initial here if you witnessed the signing of this form by the Proposed Insured(s).

ADDITIONAL MEDICAL DETAILS

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

	Provide dates, type of treatment, and results.	Name of Doctor or Hospital and Complete Address and Phone Number.
Person Question No. Condition:		
Person Question No. Condition:		
Person Question No. Condition:		
Person Question No. Condition:		
Person Question No. Condition:		
Person Question No. Condition:		
Person Question No. Condition:		
Person Question No. Condition:		
Person Question No. Condition:		
Person Question No. Condition:		

HEALTH STATEMENT (continued)

IMPORTANT! PLEASE GIVE COMPLETE DETAILS OF EACH YES ANSWER ON PAGE 5 "ADDITIONAL MEDICAL DETAILS".

		Yes	No
27.	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 Proposed Ins. ❑ Spouse ❑	❑ ❑
27a.	Have you or your spouse EVER smoked cigarettes or used tobacco products? If yes, indicate who, amount per day and year quit.	❑	❑
28.	Is any proposed insured currently taking or taken within the past 3 months, any medication or receiving medical treatment of any kind? Provide details of treatment including name and dosage of all medications.	❑	❑

REQUESTING THE REMOVAL OF A SPECIAL CLASS PREMIUM OR RIDER

29. Has there been any medical treatment for, or have you consulted with a physician concerning the condition(s) which has been ridered or rated since the covered person's effective date? ❑ Yes ❑ No If yes, provide details

_____

_____

_____

REGULAR PHYSICIAN

30. Regular physician or medical practitioner for each proposed insured: (If none, provide last doctor seen, date, reason & 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_____

Child's Name_____ Physician_____

Address_____

Date Last Seen_____ Reason & Results_____

Child's Name_____ Physician_____

Address_____

Date Last Seen_____ Reason & Results_____

HEALTH STATEMENT

IMPORTANT! PLEASE GIVE COMPLETE DETAILS OF EACH YES ANSWER ON PAGE 5 "ADDITIONAL MEDICAL DETAILS".

WITHIN THE LAST 10 YEARS HAS ANY PROPOSED INSURED:	Yes	No
17. 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?	❑	❑
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? (provide last blood pressure reading and cholesterol level if known)	❑	❑
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?	❑	❑
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?	❑	❑
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?	❑	❑
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?	❑	❑
g) The genitourinary system including but not limited to any kidney disorder, kidney stones, cystitis, prostatitis, bladder infections, or sexually transmitted disease?	❑	❑
h) Diabetes, high or low blood sugar or any disorder of the thyroid gland or other glandular disorder?	❑	❑
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?	❑	❑
j) Blood or lymph disorders including but not limited to anemia or lymphadenopathy?	❑	❑
k) Cancer? Provide location, type of cancer and treatment received	❑	❑
l) Tumor, cyst or growth of any kind; any breast or skin disorders? Provide location, state if treated or removed and date	❑	❑
m) Any disorder of the eyes, ears, (including ear infections or ear tubes), nose or throat. Tonsils or adenoids, any speech or hearing impairment?	❑	❑
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?	❑	❑
2. To the best of your knowledge, are you, your spouse or any dependent now pregnant?	❑	❑
3. Is any person not named on this application form now pregnant by any person to be insured?	❑	❑

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

QUESTIONS 4-6 FOR FEMALE APPLICANTS:		
4. Complications of pregnancy, including but not limited to caesarean section delivery or miscarriage?	❑	❑
5. DATE OF LAST PAP SMEAR_____ RESULTS_____		
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?	❑	❑
18. Been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) by a member of the medical profession?	❑	❑
19. Been diagnosed as having or been treated for any immune deficiency disorder by a member of the medical profession?	❑	❑
20. 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?	❑	❑
21. Had surgery or has diagnostic testing, treatment or surgery been recommended or scheduled that has not been completed?	❑	❑
22. 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?	❑	❑
23. 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? If yes, give name of physician or hospital and results.	❑	❑
24. 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?	❑	❑
25. Used sedatives, tranquilizers, cocaine or other hallucinogenic or narcotic drugs, or received treatment for drug abuse or chemical dependency?	❑	❑
26. To the best of your knowledge, does any person to be insured have any mental or physical impairment, disease or deformity not indicated above?	❑	❑

POLICY INFORMATION – PLEASE PROVIDE A PROPOSAL/QUOTE

BILLING

9. ❑ Quarterly ❑ Bank Draft (Complete attached form) ❑ Annual
❑ Semi-Annual ❑ Existing Account #_____

Send premium notices to: ❑ Insured ❑ Other (Print name, street number, city, state & zip)

_____

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 (Complete section below) ❑ No

Proposed Insured's Name	Company Name	Company Phone Number	Group/ Individual/ COBRA	Type of Coverage	Effective Date	Termination Date

11. Were all proposed insureds covered under the prior plan listed above? ❑ Yes ❑ No (If no, list those not covered)

_____

12. Will this proposed coverage replace or change any existing health insurance? . . . . . ❑ Yes ❑ No

13. Will any proposed insured become eligible for any other form of medical insurance in the next six months? . . . . . ❑ Yes ❑ No

14. 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 & DRIVING

15. Have any of the proposed insureds ever participated in professional motorcycling, snowmobiling, off highway vehicle riding, skiing, snowboarding or horseback riding; organized racing including but not limited to, automobile 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

16. 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 who and type of violation._____ Date/s_____