



## ASSURANT TEMPORARY HEALTH INSURANCE INSTRUCTIONS FOR COMPLETING YOUR APPLICATION

Your effective date of coverage will begin on the later of: 1) 12:01AM the day after your requested policy date; or 2) 12:01AM the day after the post mark date affixed by the U.S. Post office, provided the following conditions are met:

- ✓ Your application and the full premium payment is received by Long Term Consumer Care, Inc. or Assurant Health.
- ✓ Your answers on the application are correct and meet the requirements for acceptance.
- ✓ **Two signatures are required:** Applicant signature and Account Holder signature.

Temporary health insurance from Assurant Health will cover you while traveling anywhere in the United States and Canada. If you plan on moving (within the United States) while you are covered, simply apply in the state you currently have residence in.

Complete and sign the application and either mail or fax the application with your payment made payable to: **Assurant Health**. Incomplete applications will be returned.

If paying by Credit Card, you can fax the completed application to

Long Term Consumer Care, Inc. at: **(262) 523-1910**

**Mail your completed & signed Assurant Temporary Health Insurance application with check, money order or credit card billing information to:**

**Long Term Consumer Care, Inc.  
N27 W23960 Paul Road - Suite 201  
Pewaukee, WI 53072**

**Note:** Make check or money order payable to Assurant Health.

**If you have any questions please call us toll free at: (800) 544-9505**

Please keep this page with your Assurant temporary health insurance policy. If you need to apply for an additional term of insurance contact Long Term Consumer Care, Inc. Toll Free at: 1-800-544-9505 or visit us at: [www.consumerbenefits.net](http://www.consumerbenefits.net) or the Fortis / Assurant site located at: [www.temp-insurance.com](http://www.temp-insurance.com)

*Thank you for choosing Long Term Consumer Care, Inc.*



ASSURANT  
Health

## Short Term Medical

*Temporary Insurance for Gaps in Health Coverage*



### BETWEEN JOBS

If you're between jobs, consider Short Term Medical. For about half the cost of COBRA,\* Short Term Medical offers next-day coverage to help you bridge the insurance gap.



### WAITING FOR EMPLOYER BENEFITS

Often new employers impose a waiting period before you're eligible for health benefits. With Short Term Medical, you stay insured and can choose your own plan duration.



### TEMPORARY OR SEASONAL EMPLOYEES

When your employment schedule is unpredictable, it's hard to maintain health coverage. Short Term Medical offers you prescription drug savings and flexible coverage options to suit your situation.



### NEW GRADUATES

If you've just graduated, you're probably no longer eligible for health insurance through a student plan or your parent's plan. Short Term Medical is an affordable way to guard against unexpected medical bills until you secure permanent coverage.

\* Short Term Medical insurance is often a lower-cost alternative to COBRA. However, if you purchase Short Term Medical rather than maintaining COBRA coverage, you may give up your rights to coverage for pre-existing conditions or guaranteed health insurance in the future. This brochure provides a brief description of the important features of this plan. State mandated benefits, if applicable, are incorporated in your policy.

## Choose the protection of Short Term Medical for gaps in health insurance coverage.

Unexpected illnesses and accidents happen every day, and the resulting medical bills can be disastrous.

**Until you enroll in permanent coverage, safeguard your financial future with Short Term Medical temporary insurance. It provides the peace of mind and health care access you need at a price you can afford.**

You can depend on Short Term Medical. Assurant Health was the first provider of temporary insurance in 1973 and has remained a leader ever since.

### Receive access to the health care you need with Short Term Medical:

- Prescription drug coverage and card for instant savings
- Coverage as soon as the next day
- You may keep your own doctors



Enrollment Form Enclosed —  
Apply Today!

## Short Term Medical Benefits

With Short Term Medical, you get the following valuable benefits for unexpected illnesses and injuries. More details will appear in your enrollment kit. *Coverage starts as early as the next day!*

### PLAN FEATURES

|                                                                                                                                        |                                                                                                                                                                                                                                                 |
|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Prescription Drug Benefits                                                                                                             | <ul style="list-style-type: none"> <li>Includes prescription drug card for instant savings — on average over 30% off</li> <li>Covered (subject to deductible and coinsurance)</li> </ul>                                                        |
| Doctor Visits                                                                                                                          | <ul style="list-style-type: none"> <li>Covered for unexpected illness and injury (subject to deductible and coinsurance)</li> <li>You may keep your own doctors</li> <li>Discounts for using network doctors — on average 20-35% off</li> </ul> |
| Hospital Benefits                                                                                                                      | <ul style="list-style-type: none"> <li>Inpatient and outpatient services covered (subject to deductible and coinsurance)</li> <li>Discounts for using network facilities — on average 20-35% off</li> </ul>                                     |
| Emergency Room Care                                                                                                                    | Covered (subject to deductible and coinsurance)                                                                                                                                                                                                 |
| Ambulance                                                                                                                              | Service to nearest hospital able to treat condition                                                                                                                                                                                             |
| Outpatient Surgery                                                                                                                     | Covered (subject to deductible and coinsurance)                                                                                                                                                                                                 |
| X-ray and Laboratory                                                                                                                   | Covered (subject to deductible and coinsurance)                                                                                                                                                                                                 |
| Transplant Benefits                                                                                                                    | \$100,000 including up to \$10,000 in donor expenses                                                                                                                                                                                            |
| Deductible Choices*<br><i>(The amount you must pay before Assurant Health pays any benefits.)</i>                                      | <ul style="list-style-type: none"> <li>\$250, \$500, \$1,000, \$2,500, \$3,500 or \$5000</li> <li>Only one deductible must be satisfied for all covered family members for deductibles \$500 and higher.</li> </ul>                             |
| Coinsurance*<br><i>(Assurant Health's portion/your portion of the first \$10,000 in medical bills after you meet your deductible.)</i> | 100%, 80%/20% or 50%/50%                                                                                                                                                                                                                        |
| Lifetime Maximum<br><i>(Maximum amount your plan will pay toward medical bills per covered person.)</i>                                | \$2 million                                                                                                                                                                                                                                     |

\* Plan options may vary by state

### What's Not Covered

This Short Term Medical plan does not cover:

- Treatment of a pre-existing condition, including those not inquired about on the enrollment form
- Routine care, examinations, or immunizations
- Illness or injury that is self-inflicted or caused while engaged in a felony, under the influence of an illegal substance, driving under the influence, in military service, in a hazardous occupation or activity for which compensation is received, or playing interscholastic sports
- Vision or dental treatments, foot care, or orthotics
- Maternity, genetics, or fertility treatment or testing
- Custodial care or private nursing
- Cosmetic, experimental, investigational, or not medically necessary treatment
- Treatment of mental illness or substance abuse
- Expenses incurred outside the United States, its possessions, and Canada

## Additional Benefits and Services

### Health Advocates Alliance Membership

When you purchase Short Term Medical insurance, you are enrolled in Health Advocates Alliance, an association dedicated to the health and well-being of its members. Membership benefits include access to a 24-hour nurse helpline and discounts on vitamins and LensCrafters® purchases.

### Provider Discounts

Though you always have the option of choosing your own doctors, you can save an average of 20-35% on your medical bills by using network doctors and hospitals. Simply call the number or visit the Web site listed on your medical insurance card to check if your doctor is part of the extensive provider network.

### Patient Care

When you need help navigating the health care system, you can reach out to Patient Care, an independent health care advocacy service. A specially trained advocate will answer your questions and help resolve your concerns.

### Premium Refunds

If you are not completely satisfied with your Short Term Medical plan, you may return the policy and identification cards within 10 days of delivery for a premium refund, no questions asked. The one-time application fee is not refundable at any time.

## Follow These Four Easy Steps to Enroll:

### 1 Determine Whom to Cover

You may insure yourself, your spouse, and/or dependent children for one month or longer.

If you need coverage for a period between one and twelve months, Short Term Medical may be a good option if you do not need your plan to cover treatment for an existing medical condition. If you do, an Assurant Health individual medical plan or COBRA coverage may be better for you.

### 2 Verify Eligibility

Each person must be between the ages of 30 days and 64 years, 11 months. Dependents must be under the age of 18, or 24 if full-time students.

Look at the health questions next to the **?** symbol on the enrollment form. You will not be eligible for Short Term Medical coverage if you answer “yes” to any health question.

*Short Term Medical plans provide coverage for unexpected illnesses and injuries*, meaning they do not cover pre-existing conditions.

A pre-existing condition is a medical condition due to sickness or injury for which you received medical treatment or advice during the 5-year period immediately prior to your Short Term Medical effective date, regardless of whether the condition was diagnosed or not.

If you have a pre-existing condition, treatment for that condition will be excluded from your Short Term Medical plan.

To Apply Online, Visit: <http://www.Temp-Insurance.com>

### 3 Design Your Plan

Your Short Term Medical plan design is based on three things:

- deductible
- length of time you need coverage
- coinsurance

*Decide on the deductible right for you.*

Consider the tradeoff when choosing:

- A lower deductible means you’ll pay higher premiums (the amount you pay for your health coverage) but less out of pocket initially if you get sick or injured.
- A higher deductible means lower premiums but a greater initial sum out of pocket if you get sick or injured.

*To decide how long you need health coverage, consider your needs.*

If you pay by the month, simply stop paying when you secure permanent health insurance.

If you already know how long you’ll need coverage, you can **save 20% on your premium** by making a single, up-front payment. Your payment is due when you enroll, regardless of effective date.

If you become ill or injured while covered by a Short Term Medical plan, your benefits may be extended:

- continued coverage at no additional cost for up to 12 months if you are hospitalized
- \$1,000 in benefits at no additional cost for up to 60 days if you have a non-disabling condition

When your plan expires, you may apply for another plan. Since a Short Term Medical plan will not cover medical conditions that existed before the plan began, a new Short Term Medical plan will not provide benefits for any condition or symptom that began during a previous plan.

*Coinsurance refers to the percentage of medical bills that Assurant Health and you pay after you pay your deductible.* You are responsible for a portion of the first \$10,000 in covered charges after you meet your deductible. After that first \$10,000, Assurant Health pays 100% of covered charges up to the lifetime maximum.

Here’s an example of how much you would pay in premium, deductible, and coinsurance if you broke your leg and required \$15,000 in medical treatment.

| IF YOU CHOSE                                                                                        | EXAMPLE PREMIUM* | YOU WOULD PAY                                                                           | ASSURANT HEALTH WOULD PAY |
|-----------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------|---------------------------|
| <ul style="list-style-type: none"> <li>• \$1,000 deductible</li> <li>• 80/20 coinsurance</li> </ul> | \$86.57          | <b>\$3,000</b><br>(\$1,000 deductible + \$2,000 coinsurance [20% of the next \$10,000]) | <b>\$12,000</b>           |
| <ul style="list-style-type: none"> <li>• \$2,500 deductible</li> <li>• 80/20 coinsurance</li> </ul> | \$67.33          | <b>\$4,500</b><br>(\$2,500 deductible + \$2,000 coinsurance [20% of the next \$10,000]) | <b>\$10,500</b>           |

\* Premiums shown are per-month nationwide average for a 33-year-old.

Rates are subject to change and are based on age, plan design, and geographical area. Your rate will not change during your policy period.

**4 Calculate Your Premium and Complete the Enrollment Form**

Now it's time to calculate your premium and complete the enrollment form.

**Few things to remember:**

- The \$250 and the \$3,500 deductible options are only available with the 6 month plan.
- The \$5,000 deductible is only available with the 12 month plan.

| Chart 1 - Primary Insured/Spouse Daily Rate |            |       |         |         |         |         |
|---------------------------------------------|------------|-------|---------|---------|---------|---------|
| AGE                                         | Deductible |       |         |         |         |         |
|                                             | \$250      | \$500 | \$1,000 | \$2,500 | \$3,500 | \$5,000 |
| 0-14                                        | 2.21       | 1.45  | 1.25    | 0.95    | 0.80    | 0.68    |
| 15-19                                       | 2.81       | 1.90  | 1.55    | 1.25    | 1.10    | 1.03    |
| 20-24                                       | 2.51       | 1.70  | 1.50    | 1.10    | 0.95    | 0.88    |
| 25-29                                       | 2.66       | 1.69  | 1.38    | 0.97    | 0.95    | 0.78    |
| 30-34                                       | 2.86       | 1.90  | 1.35    | 1.05    | 1.00    | 0.78    |
| 35-39                                       | 3.31       | 2.26  | 1.70    | 1.20    | 1.10    | 1.03    |
| 40-44                                       | 3.81       | 2.51  | 2.01    | 1.45    | 1.25    | 1.13    |
| 45-49                                       | 4.42       | 2.96  | 2.51    | 1.75    | 1.50    | 1.43    |
| 50-54                                       | 6.03       | 4.02  | 3.36    | 2.51    | 2.16    | 1.98    |
| 55-59                                       | 7.83       | 5.47  | 4.42    | 3.26    | 2.81    | 2.59    |
| 60-64                                       | 12.81      | 8.59  | 7.08    | 5.07    | 4.37    | 4.10    |

| Chart 2 - Dependent Child Daily Rate |            |       |         |         |         |         |
|--------------------------------------|------------|-------|---------|---------|---------|---------|
| AGE                                  | Deductible |       |         |         |         |         |
|                                      | \$250      | \$500 | \$1,000 | \$2,500 | \$3,500 | \$5,000 |
| Per Child                            | 1.40       | 0.90  | 0.80    | 0.50    | 0.50    | 0.45    |

| Chart 3 - Zip Code Factor |      |
|---------------------------|------|
| Zip Code                  |      |
| 162-181                   | 1.49 |
| 190, 191                  | 1.95 |
| All other                 | 1.66 |

To Apply Online, Visit: <http://www.Temp-Insurance.com>

| Premium Calculation Instructions                                                                                                                                                                                                                  |                                                                         |                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------|
| <i>Refer to charts on the left when figuring the premium</i>                                                                                                                                                                                      |                                                                         |                 |
| <b>Step 1.</b> Choose a payment option - single or monthly                                                                                                                                                                                        | Single Payment                                                          | Monthly Payment |
| <b>Step 2.</b> List each applicant's daily rate. Rate chart is set up by age and deductible*.<br>a) Primary insured rate .....                                                                                                                    | _____                                                                   | _____           |
| b) Spouse rate .....                                                                                                                                                                                                                              | + _____                                                                 | + _____         |
| (see Chart 1)                                                                                                                                                                                                                                     |                                                                         |                 |
| <b>SUBTOTAL =</b>                                                                                                                                                                                                                                 | _____                                                                   | _____           |
| <b>Step 3.</b> List the per child rate (Chart 2). Enter the number of dependent Child(ren). Multiply the rate by the number of children.                                                                                                          | x _____                                                                 | x _____         |
| <b>SUBTOTAL =</b>                                                                                                                                                                                                                                 | _____                                                                   | _____           |
| <b>Step 4.</b> Add the subtotal from Step 2 & 3.                                                                                                                                                                                                  | _____                                                                   | _____           |
| <b>Step 5.</b> Monthly factor. Multiply by the subtotal in Step 4.                                                                                                                                                                                | x 1.00                                                                  | x 1.28          |
| <b>SUBTOTAL =</b>                                                                                                                                                                                                                                 | _____                                                                   | _____           |
| <b>Step 6.</b> Enter Zip Code Factor (Chart 3). Multiply by subtotal in Step 5.                                                                                                                                                                   | x _____                                                                 | x _____         |
| <b>SUBTOTAL =</b>                                                                                                                                                                                                                                 | _____                                                                   | _____           |
| <b>Step 7.</b> Plan Type<br>- 6 month plan (30-180 days) enter 1.00.<br>- 12 month plan (181-360 days) enter 1.30.<br>Multiply by the subtotal in Step 6.                                                                                         | x _____                                                                 | x _____         |
| <b>SUBTOTAL =</b>                                                                                                                                                                                                                                 | _____                                                                   | _____           |
| <b>Step 8.</b> Enter the number of days of coverage. Multiply the number of days by the subtotal in Step 7.                                                                                                                                       | x _____<br><small>Minimum 30 Maximum 360</small>                        | x 30            |
| <b>SUBTOTAL =</b>                                                                                                                                                                                                                                 | _____                                                                   | _____           |
| <b>Step 9.</b> Rate of Payment<br>• 100%, enter 1.25<br>Available with 6 Month Plan (30-180 days) only, with \$500, \$1,000, \$2,500 and \$3,500 deductibles<br>• 80/20, enter 1.00<br>• 50/50, enter 0.80<br>Multiply by the subtotal in Step 8. | x _____                                                                 | x _____         |
| <b>SUBTOTAL =</b>                                                                                                                                                                                                                                 | _____                                                                   | _____           |
| <b>Step 10.</b> Application Fee** (Non refundable)<br>Add fee to subtotal in Step 9.                                                                                                                                                              | + \$25.00                                                               | + \$25.00       |
| <b>TOTAL =</b>                                                                                                                                                                                                                                    | _____                                                                   | _____           |
| *Choose one deductible amount per policy<br>** Application fee is added to first month's premium only                                                                                                                                             | <b>Enter this amount on the enrollment form in the box marked TOTAL</b> |                 |

**Tips and Additional Information**

**Submitting Your Enrollment Form and Payment**

Please check that you have:

- answered all questions on the enrollment form
- included necessary signatures
- enclosed your payment

**When Your Coverage Begins**

Your coverage will begin at 12:01 a.m. on your approved effective date as long as your enrollment form is complete, meets the requirements for acceptance, and includes the initial premium. Your requested effective date must fall within 45 days of the date you signed the enrollment form.

Upon enrollment, you will receive a welcome kit containing your insurance card and coverage details.

For more information, or for help applying for coverage, contact your insurance agent.

OR if you would like to submit your enrollment form directly to Assurant Health you can mail it to:

**Assurant Health**  
P.O. BOX 3175  
Milwaukee WI 53201-3175

OR Fax your enrollment form to: 414-299-1137

**About Assurant Health**

Assurant Health has been in business since 1892 and is the brand name for products underwritten and issued by Time Insurance Company, John Alden Life Insurance Company and Union Security Insurance Company. The Assurant Health Web site is [www.assuranthealth.com](http://www.assuranthealth.com).

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

|                          |     |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                           |
|--------------------------|-----|------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|
| REQUESTED EFFECTIVE DATE |     |      | Note: Effective date is assigned by Time Insurance Company. The effective date is the later of: 1. The day after:<br>a) the date this form is signed; b) the date this form is postmarked for mailing to Time Insurance Company; or<br>c) the date we receive your enrollment request by electronic transmission in our home office, OR 2. If dates cannot be<br>determined, the day we receive this form by mail. <b>The agent cannot assign an effective date different than this.</b> | 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 NAME (if to be insured) | GENDER | BIRTH DATE | SOCIAL SECURITY NUMBER |
|----------------------------------|--------|------------|------------------------|

|                                          |            |            |            |            |            |
|------------------------------------------|------------|------------|------------|------------|------------|
| CHILDREN'S NAME (if to be insured)<br>1. | BIRTH DATE | NAME<br>2. | BIRTH DATE | NAME<br>3. | BIRTH DATE |
|------------------------------------------|------------|------------|------------|------------|------------|

**Note: The plan cannot be issued if YES is answered to questions 1 - 2. Under no circumstances can coverage become effective prior to the date this application is signed.**

**Answer the following questions completely and accurately.** YES NO

1. Have/Are you, your spouse, or any person to be insured:  YES  NO
  - ◆ been denied insurance due to any health reasons that are still present? ◆ 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?
2. 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 including but not limited to heart attack or chest pain? ◆ AIDS or tested positive for HIV? ◆ diabetes?
  - ◆ Emphysema? ◆ stroke? ◆ cancer or tumor?
  - ◆ Crohn's disease, ulcerative colitis or hepatitis? ◆ kidney disorder, excluding kidney stones? ◆ alcoholism, chemical dependency, drug or alcohol abuse?
3. Will this proposed coverage replace any existing health insurance? (if yes, replacement notice 28949 must be included with the application).  YES  NO

| DEDUCTIBLE AMOUNT                                                                                                                                                                                             | PAYMENT OPTION AND LENGTH OF COVERAGE                                                                                                                                                                                                                                 | RATE OF PAYMENT                                                                                                                | TOTAL |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|-------|
| <input type="checkbox"/> \$ 250* <input type="checkbox"/> \$ 500 <input type="checkbox"/> \$ 1,000 <input type="checkbox"/> \$ 2,500 <input type="checkbox"/> \$ 3,500** <input type="checkbox"/> \$ 5,000*** | <input type="checkbox"/> Single Payment - Total number of days needed _____<br><input type="checkbox"/> Monthly Payment - Coverage is needed for:<br><input type="checkbox"/> up to 6 months (30-180 days)<br><input type="checkbox"/> up to 12 months (181-360 days) | <input type="checkbox"/> 100%* <input type="checkbox"/> 80% <input type="checkbox"/> 50%                                       |       |
| * Available only with the 6 month plan.<br>** Available only with the 6 month plan and 100% Rate of Payment.<br>*** Available only with the 12 month plan for policies of 181-360 days.                       |                                                                                                                                                                                                                                                                       | * Available only with the 6 month plan for policies of 30 - 180 days with the \$500, \$1,000, \$2,500 and \$3,500 deductibles. |       |

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. The undersigned understands that the plan applied for will not pay benefits for any expenses incurred on account of any condition which manifested itself before the effective date. The undersigned also understands that this is not a continuation of any previous medical plan, including any prior Short Term Medical plan. 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 |
|-----------------------------------|--------------------------------------|

|                       |              |
|-----------------------|--------------|
| APPLICANT'S SIGNATURE | TODAY'S DATE |
|-----------------------|--------------|

|                      |                          |
|----------------------|--------------------------|
| DAY TELEPHONE NUMBER | EVENING TELEPHONE NUMBER |
|----------------------|--------------------------|

FORM 28786.PA

**Electronic Policy Option**

I would like to receive my policy and the company's "Notice of Privacy Practice" via the Internet.  Yes  No EMAIL ADDRESS

To receive policy delivery via the Internet, you must provide your email address in the space to the right. ➔

**Payment Information**

**Step 1: Select a Method of Payment:**  MasterCard    Visa    Check    Automatic charge to checking account (Only available with the Monthly Payment Option)  
Please submit first month premium via check along with a separate voided check.

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 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.

Card # --- Exp. Date: \_\_\_\_/\_\_\_\_ Authorized Amount \$ \_\_\_\_\_ (Insert Initial Premium Payment Amount)

|                            |      |                          |
|----------------------------|------|--------------------------|
| ACCOUNT HOLDER'S SIGNATURE | DATE | APP SOURCE <b>TICFAX</b> |
|----------------------------|------|--------------------------|

**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 right to participate in all programs offered by the Association. Information regarding the benefits provided by the Association will be sent under separate cover. The premium includes your membership in Health Advocates Alliance.  
 I hereby request enrollment in the Health Advocates Alliance.

|                            |                    |      |
|----------------------------|--------------------|------|
| MEMBER NAME (Please print) | MEMBER'S SIGNATURE | DATE |
|----------------------------|--------------------|------|

|            |            |                                          |
|------------|------------|------------------------------------------|
| AGENT NAME | AGENT ID # | CONFIRMATION CODE (HOME OFFICE USE ONLY) |
|------------|------------|------------------------------------------|