



Assurant Health Short Term 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.

Short term 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 payment made payable to: **Assurant Health**. Incomplete applications will be returned.

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

Fax Application To: (262) 523-1910

Mail your completed & signed Assurant Short Term 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/temp.htm or the Assurant Health site located at: www.temp-insurance.com

Thank you for choosing Long Term Consumer Care, Inc.

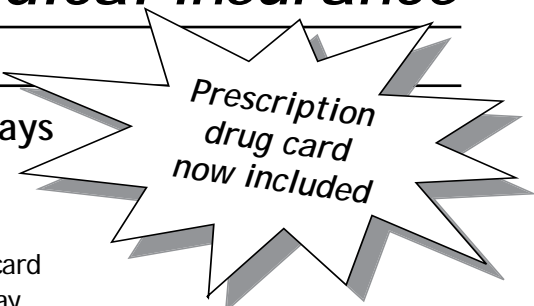


Short Term Medical Insurance

CALIFORNIA

Coverage for 30 - 185 Days

- ✓ Up to \$2 million in coverage
- ✓ Visit any doctor, any hospital
- ✓ Prescription drug coverage & card
- ✓ Coverage as early as the next day



Simple. Fast. Affordable.

Our lives are constantly changing, as are our priorities. However, one priority that should never change is ensuring you and your family are protected against an unexpected illness or injury – both medically and financially.

Even if you're healthy, you're not immune from the unexpected. If you find yourself temporarily without health coverage, **Short Term Medical** insurance is an affordable solution that provides valuable basic protection against an unexpected illness or accident. **Short Term Medical** insurance is:

Simple – You get coverage for unexpected illnesses and accidents; pre-existing medical conditions are not covered.

Fast – Coverage can be obtained as early as the next day ... just a few simple medical questions to answer. Best of all, you can choose to receive your policy electronically.

Affordable – You design the plan that best meets your needs and budget. **Short Term Medical** insurance is a low-cost option for your temporary need and may also be a low-cost alternative to COBRA.

The plan comes with a variety of rate of payment (coinsurance) and deductible options, as well as a choice of single or monthly payments – giving you control over your premiums and out-of-pocket expenses.

With \$2 million in coverage and the option to visit any doctor or hospital, there's no good reason to go without health insurance, even for a short time.

Who you choose matters! An insurance plan is only as reliable as the company behind it. Assurant Health has been in business since 1892, selling health insurance longer than any of its competitors. Assurant Health is the brand name for products underwritten and issued by John Alden Life Insurance Company, which is consistently rated A- (Excellent) by A.M. Best¹. For health insurance you can depend on, insist on a track record of expertise, strength and commitment – insist on Assurant Health.

¹ Source: A.M. Best Ratings and Analysis, June, 2006.

To preserve your rights to guaranteed health insurance and coverage for pre-existing conditions, you may need to purchase up to 18 months of COBRA. You may forego these rights when you purchase a Short Term Medical plan or choose to go without insurance.

Assurant Health is the brand name for products underwritten and issued by John Alden Life Insurance Company.

Temporary Health Insurance for People Who Are:

- Between jobs or laid off
- Looking for a lower-cost alternative to COBRA
- Recent college graduates
- Waiting for employer-sponsored coverage
- Temporary or seasonal employees

Who's Eligible for This Plan?

- Healthy individuals between the ages of 30 days and 64 years, 11 months.
- Dependent children through age 18 (age 24 if full-time student) may be covered as dependents on their parent's plan.
- Foreign residents living in the U.S. for at least one year at the time of enrollment, with proof of Alien Registration Receipt Card, visa or other appropriate documentation.

Plan Highlights

- Freedom to choose your own doctors and hospitals
- Prescription drug coverage
- In-hospital and out-patient benefits
- Coverage continues beyond the policy period for up to 12 months if you are hospitalized – at no additional cost
- \$1,000 extension of benefit beyond the policy period for up to 60 days for a non-disabling condition – at no additional cost

Prescription Drug Coverage

Prescription drugs are expensive. This plan provides coverage for generic and brand name prescription drugs needed as a result of an accident or illness you experience while covered by this plan.

- Visit any pharmacy
- No separate deductible to meet
- No limit on the number of prescriptions that can be filled

NEW Prescription Drug Card

This plan covers prescription drugs. When you present your prescription card at a participating pharmacy, you may receive additional savings along with having your prescription claim sent to Assurant Health automatically.

To locate your nearest participating pharmacy, call the number on the back of your prescription card.

Reduce Your Medical Costs


You may be able to reduce your medical bills by using the doctors and hospitals participating in the PHCS Healthy Directions provider network. Simply call or go online to see if your doctor or hospital is part of PHCS Healthy Directions:

- 1-800-357-6847
- www.phcs.com

Design the Plan That's Right for You

	6 Month Plan
Length of Coverage	30-185 days Up to 6 monthly payments
Deductible Amount you pay toward covered expenses before the plan pays benefits	\$250*, \$500, \$1,000, \$2,500 Only one deductible needs to be satisfied for all covered members. *For the \$250 deductible only — each family member needs to satisfy the deductible (up to a maximum of three deductibles).
Rate of Payment (Coinsurance) Percentage of covered expenses we pay after the deductible	100%, 80%, 50% The 100% option is only available with the \$1,000 and \$2,500 deductible options.
Lifetime Benefit Maximum The total maximum amount the plan pays	\$2 million

Benefits are paid as follows:

FIRST	You pay the deductible.		
	100%	80/20	50/50
THEN		You pay 20% of the next \$10,000 up to a maximum of \$2,000.	You pay 50% of the next \$10,000 up to a maximum of \$5,000.
THEREAFTER	We pay 100% of remaining covered expenses up to the plan maximum of \$2 million for each covered person.		

Plan Exclusions

This Short Term Medical plan does not cover: pre-existing conditions* (including those not inquired about on the enrollment form); preventive or wellness doctor visits; dental or optical treatments; routine physical exams; normal pregnancy or childbirth; well child care; interscholastic and intercollegiate sports injuries; expenses incurred outside the United States, its possessions, territories or Canada. **Other exclusions are listed in detail in the policy you will receive when you purchase Short Term Medical.**

* Pre-existing Condition: A medical condition due to sickness or injury for which medical advice, diagnosis, treatment, including the use of prescription drugs, was recommended or received from a Health Care Practitioner within the 6-month period immediately preceding the Effective Date of coverage.

When Does Coverage Begin?

Your coverage will begin at 12:01 a.m. the day of your approved effective date, provided the enrollment form received is complete*, meets the requirements for acceptance and the full initial premium is received. Your requested effective date must be within 45 days from the date you signed the enrollment form.

Please refer to the enrollment form on the back of this brochure for more information on determining your effective date.

* Enrollment forms that do not meet eligibility requirements will be returned to the insured or agent. Incomplete enrollment forms may be returned and/or re-dated by Assurant Health.

Two Convenient Payment Options

Paying for your Short Term Medical plan is easy with two convenient payment options:

- **Single Payment Option:** Ideal if you know the exact number of days coverage is needed. The minimum number of days you may apply for is 30 days, the maximum is 185 days. **No refunds are available after the 10-day free look period.**
- **Monthly Payment Option:** Ideal if you are unsure how long coverage is needed. This "pay as you go" option gives you the flexibility to continue coverage for as long as it's needed or simply stop payments and discontinue the plan once your temporary need ends.

Purchasing an Additional Plan

This Short Term Medical plan is not renewable. However, if your temporary need continues beyond your policy period, you may apply for a new plan under the following condition:

- No claims were submitted to us while covered under one of our previous **Short Term Medical** plans, for you or any member of your family who is to be covered.

Any previous or current health condition or symptom will be considered a pre-existing medical condition that will not be covered under a new plan. There is no continuous coverage between plans -- therefore your new plan will not provide benefits for any condition or symptom which began during a previous plan. In addition, no benefits are available for any period in which you are not covered by our Short Term Medical plan.

Premium Refunds

If you are not 100 percent satisfied with the plan, you may return the policy and identification cards within 10 days of delivery for a premium refund. No questions asked! **After the 10-day free look period, premiums are not refundable.**

The \$20 application fee is non-refundable.

Apply Now!

Applying for Short Term Medical coverage is easy.

- Calculate the premium for the coverage of your choice.
Refer to the Premium Calculation Instructions section to the right.
- Complete all information, sign and date the enrollment form.
- Mail the completed enrollment form with your payment to your agent or Assurant Health, P.O. Box 3175, Milwaukee, WI 53201-3175.

Checks and Money Orders should be made payable to:
Assurant Health.

If you have any questions, please contact the agent listed on the brochure at 1-800-544-9505.

Chart 1 – Primary Insured/Spouse Daily Rate				
Age	Deductible			
	\$250	\$500	\$1,000	\$2,500
0-14	\$2.20	\$1.45	\$1.25	\$0.95
15-19	2.80	1.90	1.55	1.25
20-24	2.50	1.70	1.50	1.10
25-29	2.60	1.65	1.35	0.95
30-34	2.85	1.90	1.35	1.05
35-39	3.35	2.30	1.75	1.25
40-44	3.80	2.50	2.00	1.45
45-49	4.40	2.95	2.50	1.75
50-54	6.00	4.00	3.35	2.50
55-59	7.80	5.45	4.40	3.25
60-64	12.75	8.55	7.05	5.05

Note: Only use the rates above for the primary insured and spouse. See chart below for dependent child rates.

Chart 2 – Dependent Child Daily Rate				
	Deductible			
	\$250	\$500	\$1,000	\$2,500
Per Child	\$1.40	\$0.90	\$0.80	\$0.50

Chart 3 – ZIP Code Factor Table	
Find the first three digits of your resident address ZIP code in the ZIP Code column. Locate the multiplication factor in the Factor column. If your specific ZIP code is not shown, use the all others factor. ZIP codes shown together are inclusive. (Example: 330-333 includes 330, 331, 332, 333.)	
ZIP Code	Factor
900-907, 918	3.21
908-917, 946-947	2.69
All other California	2.05

Chart 4 – Deductible & Rate of Payment Factor Table				
	\$250	\$500	\$1,000	\$2,500
50%	0.80	0.88	0.80	0.80
80%	1.10	1.10	1.00	1.00
100%	n/a	n/a	1.34	1.22

Premium Calculation Instructions		
Refer to charts on previous panel.		
Step 1. Choose a payment option – single or monthly.	SINGLE PAYMENT	MONTHLY PAYMENT
Step 2. List each applicant's daily rate. Rate chart is set up by age and deductible. a) Primary Insured rate b) Spouse rate (See Chart 1) Subtotal	_____ + _____ = _____	_____ + _____ = _____
Step 3. List the per child rate (see chart on previous panel). ... Enter the number of dependent children. Multiply the rate by the number of children. (See Chart 2) Subtotal	_____ x _____ = _____	_____ x _____ = _____
Step 4. Add the subtotals from Steps 2 & 3.	= _____	= _____
Step 5. Monthly Factor Multiply by the subtotal in Step 4. Subtotal	x 1.00 = _____	x 1.25 = _____
Step 6. Multiply the ZIP Code Factor by the subtotal in Step 5 (See Chart 3) Subtotal	x _____ = _____	x _____ = _____
Step 7. Enter the number of days of coverage Multiply the number of days by the subtotal in Step 6. Subtotal	x _____ Minimum is 30 days. Maximum is 185 days. = _____	x 35 Subsequent monthly payments will be less as they are based on 30 day increments. To determine future monthly premiums repeat the calculation using 30 days. = _____
Step 8. Rate of Payment Multiply Rate of Payment factor by the subtotal in Step 7. (See Chart 4) Subtotal	x _____ = _____	x _____ = _____
Step 9. Application Fee (Non-refundable)	+ 20.00 = _____	+ 20.00* one-time fee only = _____
TOTAL	= _____	= _____
† Choose one deductible amount per policy. * Application fee is added to first month's premium only.		Enter this amount on the enrollment form in the box marked TOTAL.

This plan is not available to residents of Hawaii, Massachusetts, New Jersey, New York and Vermont.

This brochure provides a brief description of the important features of this plan. This is not the insurance policy. The actual plan sets forth in detail the rights and obligations of both you and your insurance company. State mandated benefits, if applicable, are incorporated in your policy.

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Short Term Medical Enrollment Form			John Alden Life Insurance Company			CALIFORNIA																																																					
REQUESTED EFFECTIVE DATE			Note: Effective date is assigned by John Alden Life Insurance Company. The effective date is the later of: 1. The day after: a) the date this form is signed; b) the date this form is postmarked for mailing to John Alden Life Insurance Company; or c) the date we receive your enrollment request by electronic transmission in our home office, OR 2. If dates cannot be determined, the day we receive this form by mail. The agent cannot assign an effective date different than this.				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)		BIRTH DATE	NAME	BIRTH DATE	NAME	BIRTH DATE																																																					
1.		2.		3.		BIRTH DATE																																																					
<p>Note: The plan cannot be issued if YES is answered to any questions. Under no circumstances can coverage become effective prior to the date this application is signed.</p> <p>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.</p> <table style="width:100%; border: none;"> <tr> <td style="width: 85%;"></td> <td style="text-align: center; width: 5%;">YES</td> <td style="text-align: center; width: 5%;">NO</td> </tr> <tr> <td>1. Will you or any person to be insured have any other hospital, Major Medical, or group health insurance in force on the effective date of this plan?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>2. Have you or any person to be insured filed a claim under a prior STM with us?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>3. Have/Are you, your spouse, or any person to be insured:</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="padding-left: 20px;">◆ been denied insurance due to any health reasons that are still present?</td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">◆ over 300 pounds if male, or over 250 pounds if female?</td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">◆ now pregnant, an expectant parent, in the process of adopting a child or undergoing infertility treatment?</td> <td></td> <td></td> </tr> <tr> <td>4. In the past 15 days, have you or any person to be insured: taken prescription medication for any medical condition, been seen by a member of the medical profession for a medical condition, or been hospital confined?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="3" style="font-size: x-small;">This question should not be answered yes if the only medication taken is birth control medication for the prevention of pregnancy.</td> </tr> <tr> <td>5. 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?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>6. 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:</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="padding-left: 20px;">◆ heart disorder including but not limited to heart attack or chest pain?</td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">◆ Emphysema?</td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">◆ Crohn's disease, ulcerative colitis or hepatitis?</td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">◆ AIDS/ARC?</td> <td></td> <td style="padding-left: 20px;">◆ diabetes?</td> </tr> <tr> <td style="padding-left: 20px;">◆ stroke?</td> <td></td> <td style="padding-left: 20px;">◆ cancer or tumor?</td> </tr> <tr> <td style="padding-left: 20px;">◆ kidney disorder, excluding kidney stones?</td> <td></td> <td style="padding-left: 20px;">◆ alcoholism, chemical dependency, drug or alcohol abuse?</td> </tr> </table>										YES	NO	1. Will you or any person to be insured have any other hospital, Major Medical, or group health insurance in force on the effective date of this plan?	<input type="checkbox"/>	<input type="checkbox"/>	2. Have you or any person to be insured filed a claim under a prior STM with us?	<input type="checkbox"/>	<input type="checkbox"/>	3. Have/Are you, your spouse, or any person to be insured:	<input type="checkbox"/>	<input type="checkbox"/>	◆ been denied insurance due to any health reasons that are still present?			◆ over 300 pounds if male, or over 250 pounds if female?			◆ now pregnant, an expectant parent, in the process of adopting a child or undergoing infertility treatment?			4. 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<input type="checkbox"/> \$ 250	<input type="checkbox"/> \$ 1,000	<input type="checkbox"/> Single Payment - Total number of days needed _____			<input type="checkbox"/> 100%*	<input type="checkbox"/> 80%	<input type="checkbox"/> 50%																																																				
<input type="checkbox"/> \$ 500	<input type="checkbox"/> \$ 2,500	<input type="checkbox"/> Monthly Payment - Coverage for up to 6 months			* available with \$1,000 or \$2,500 deductible																																																						
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. 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. 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 JT-1147, CA																																																											
Electronic Policy Option																																																											
I would like to receive my policy and the company's "Notice of Privacy Practice" via the Internet. <input type="checkbox"/> Yes <input type="checkbox"/> No						EMAIL ADDRESS																																																					
To receive policy delivery via the Internet, you <u>must</u> provide your email address in the space to the right. ➡																																																											
Payment Information																																																											
Step 1: Select a Method of Payment: <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa <input type="checkbox"/> Check <input type="checkbox"/> Automatic charge to checking account (Only available with the Monthly Payment Option)																																																											
<i>Please submit first month premium via check along with a separate voided check.</i>																																																											
Important Reminders: The \$20 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																																																					
AGENT ID # 70285-1			LTCC, INC 1-800-544-9505			CONFIRMATION CODE (HOME OFFICE USE ONLY)																																																					
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