Tele-App Part 1 Application for Medical Insurance for Individuals and Families

Agent Information

Agency Name _____ **Agency Number** _____

Agent Name Mark Erickson **Agent Number** 00038732100001

Agent Fax Number 303-484-3966 **Agent Phone Number** 303-456-7467

Agent E-mail Address mark-j-erickson@comcast.net

Person(s) To Be Insured

Name	Last	First	M.I.	Sex	Date of Birth	Social Security Number
(Primary) 1.						
(Spouse) 2.						

3. Dependent Children

Name	Last	First	M.I.	Sex	Date of Birth	Social Security Number

4. Resident Address (Street, City, State and ZIP code. No P.O. Boxes)

Street City State ZIP

5. Home Phone Number _____ 6. E-Mail Address: _____

7. Are any of the proposed insureds covered by any type of medical insurance? ❑ Yes (complete section below) ❑ No (go to Billing)

- You normally do not require more than one policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid or Medicare and may not need an accident and sickness policy. If you are eligible for Medicare, you may want to purchase a Medicare Supplemental policy.
- If you are eligible for Medicare due to age or disability, counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program.

Proposed Insured's Name	Insurance Company Name	Insurance Company Phone Number	Group (G) or Individual (I)	Type of Coverage	Effective Date	Term Date	Is this coverage being replaced by proposed coverage?

8. Are you covered for medical assistance through the state Medicaid program?
   a. As a Specified Low Income Medicare Beneficiary (SLMB)? ❑ Yes ❑ No
   b. As a Qualified Medicare Beneficiary (QMB)? ❑ Yes ❑ No
   c. For other Medicaid medical benefits? leave blank for Monthly Payment ❑ Yes ❑ No

Billing

☒ **Check-O-Matic**
(Complete form on next page and authorization below)

I (we) hereby authorize Time Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, indicated on the other side, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

X _____
Signature of Payor

X _____
Date Signed

❑ **Quarterly** ❑ **Semi-Annual** ❑ **Annual**
(If billing address is different than above, complete section below)

Name

Address

City State ZIP

REMEMBER TO FAX PAGES 1 & 2 AND THE SOFTWARE PROPOSAL!

Choose the following option that applies:

☒ **To begin Check-O-Matic withdrawals:**

X Select a desired withdrawal day: (1–28): _____

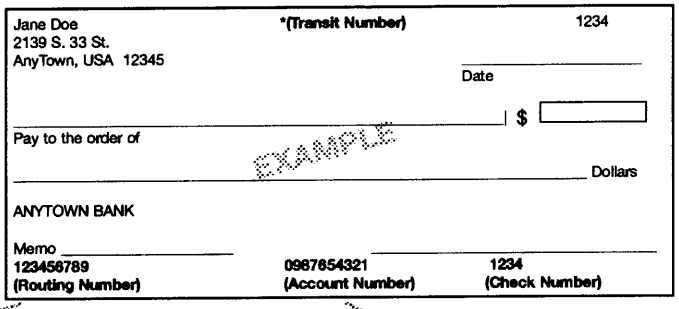
Bank Name _____

City _____ State _____

*☐ **To add this policy to an existing Check-O-Matic:**

Existing COM Number _____

Associated Policy Number _____



Routing & Transit Numbers _____ Account Number _____

9 Digits

You must either submit a voided check, or complete the routing and account information. Do not send a deposit slip. Please print clearly.

Authorization To Obtain Medical Records and Attestation

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

I represent to the best of my knowledge and belief, that all statements and answers on Part 1 are complete and true. My recorded personal health history, Part 1 and any amendments shall be the basis for the contract. I also agree that: (1) I must call Time Insurance Company and complete the telephone portion of the application process within 10 days of commencement of the application process and subsequently provide any and all medical information related thereto. (2) I understand that if at any time through the application process any of the previous information provided becomes inaccurate or is updated, I have an obligation to contact Time Insurance Company and advise of such change. (3) Within 30 days of policy delivery, I must formally accept the offer by verifying the accuracy of the application form information with a signature and returning that signed acceptance to Time Insurance Company. (4) 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 and accepted by me. (5) I understand and agree that any information I provide through this application process may be shared with persons necessary to facilitate issuing coverage, including but not limited to my agent or broker. (6) If any of these conditions are not met, Time Insurance Company has the right to rescind its offer of coverage and the full extent of its liability shall be limited to the sum received.

X _____ _____

Signature of Primary Proposed Insured | Signature of Spouse or Other Insured (if proposed to be insured)

(Circle one)
A.M. / P.M.

X _____ _____ _____ _____

Date Signed | Time Signed | City & State | Requested Policy Effective Date

Conditional Receipt Given? ☐ **Yes** ☒ **No**

REMEMBER TO FAX PAGES 1, 2 & 3, AND THE SOFTWARE PROPOSAL!

Determination of Self-Employed Business Group of One

Colorado House Bill 97-1323 establishes rules for the issuance of medical policies to a Business Group of One. In order to determine whether or not you are a Business Group of One, all applicants must read and complete the following questions.

A person who answers "yes" to all four questions below meets the legal definition of a "self-employed business group of one" in Colorado.

1. Are you either a self-employed person with no employees, or a sole proprietor who is not offering or sponsoring health care coverage to your employees?
   ❑ Yes ❑ No

2. Have you carried on a significant business activity as a self-employed person or sole proprietor for a period of at least one year prior to application for coverage?
   ❑ Yes ❑ No

3. Do you have gross income from your self-employment or sole proprietorship as indicated on Federal Internal Revenue forms 1040, Schedule C, F, or SE, or other forms recognized by the Federal Internal Revenue Service for income reporting purposes from which you have derived a substantial part of your income from your business as a self-employed person or sole proprietor for one year out of the past three years? Note: Substantial part of your income means income derived from business activities of the business group of one that are sufficient to pay for the annual premiums for the business group of one's health benefit plan.
   ❑ Yes ❑ No

4. Do you work a minimum of 24 hours a week on a permanent basis?
   ❑ Yes ❑ No

I, _____, certify that the answers to the questions contained in this form are true and correct.
(Name of applicant)

X _____ _____ _____
Signature of Applicant | Applicant's Business | Date

X **If you answered "yes" to all four questions above, please read and sign the Disclosure Statement below.**

BUSINESS GROUP OF ONE DISCLOSURE STATEMENT

Please read and sign the following disclosure required by Colorado law:

I, _____ (name of applicant), meet the definition of a self-employed business group of one as attested to on the accompanying Determination of Self-Employed Business Group of One Form. I understand that by purchasing an individual policy instead of a small group policy I give up what would otherwise be my right to purchase, during open enrollment periods as specified by law, a business group of one Standard, Basic, or other small group health benefit plan from a small employer carrier for a period of three (3) years after the effective date of the individual health benefit plan for which I am applying. I understand that this will be the case unless a small employer carrier voluntarily permits me to purchase a small group policy within such three (3) year period.

I understand that the factors used to set new and renewal rates for the individual policy I want to purchase consist of benefit options chosen, ages of each covered person, gender, smoke/non-smoker, health status, geographic location, medicare eligibility, health care cost trend, administrative costs, pre-existing conditions, claims experience of the plan, and length of time on the policy. By comparison, the rating factors that would apply if I purchased a small group business group of one policy are limited to plan design, the carrier's overall cost and utilization trends ("index rate"), my age, my family size, and a factor that reflects the cost of care where I live.

I have been given a health plan description form showing the benefits under Colorado's small group Standard Health Benefit Plans. I have also been given a Colorado Health Plan Description Form for the plan for which I am applying.

REMEMBER TO FAX PAGES 1, 2 & 3, AND THE SOFTWARE PROPOSAL!

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.

X _____

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

ASSURANT
Health

COLORADO NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to the information furnished by you, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Time Insurance Company. Your new policy will provide 10 days within which you may decide without cost whether you decide to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER OR PRODUCER

I have reviewed your current accident and sickness insurance coverage. To the best of my knowledge, this accident and sickness policy will not duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s)

(check one):

- ☐ Additional Benefits
- ☐ No change in benefits, but lower premiums
- ☐ Fewer benefits and lower premiums
- ☐ Other (Please specify) _____

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of claim for benefits under the new policy, whereas a similar claim may have been payable under your present policy.

2. State law provides that your replacement policy or contract may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The issuer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.

3. If you wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy has never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Producer or Other Representative _____ Date _____

X _____ Applicant's Signature _____ Date _____