



## Texas Health Access Plan B or C

### *Limited Medical Questions to Qualify*

**Thank you for applying for health insurance through Assurant Health.** Review the Assurant Affordable Health Access product brochure so you understand the benefits and limitations of Health Access Plan B or C. Talk to your agent to make sure the limited-benefit plan you're applying for is best suited to your needs.

### **Follow these steps to enroll now!**

1. **Decide who you want to cover** — just you, you and your spouse, just your children, or your entire family. If more than one adult person is applying, choose the youngest adult as the primary insured.
2. **Decide which Health Access Plan is right for you** — B or C.
3. **Decide if you want additional options** — you'll find value in these optional benefits.
  - Dental-Vision Discount Plan
  - Optional Rehabilitative and Habilitative Therapies For Children Benefit (4648-TX) – you must elect or decline this benefit on the Optional Rehabilitative and Habilitative Therapies For Children Benefit offer form enclosed. The form must be signed, dated and sent with the enrollment form whenever:
    - There is a dependent on the policy age 24 or younger or
    - The primary or spouse is age 17 or younger
4. **For quick approval, fully complete the enrollment form and optional benefit elections with your agent, including:**
  - All required questions
  - Requested effective date
  - Signatures — which are required for all applicants age 18 and older (child-only policies need a parent or guardian signature)
  - Optional Rehabilitative and Habilitative Therapies For Children Benefit offer form, when required

Agent: Leave this sheet with your client



# Health Access Plans B or C Texas Rate Sheet

Get quick pricing information on Assurant Affordable Health Access Plans from the monthly rate tables below. Just pick your plan, locate the primary applicant's age and who will be covered, then **circle** your monthly rate and copy it into the "CALCULATE YOUR TOTAL PREMIUM" box below. If more than one adult person is applying, choose the youngest adult as the primary insured.

For child-only policies, the youngest is the primary.

HEALTH ACCESS PLAN B MONTHLY RATES					
AGE	0-17	18-30	31-40	41-50	51-63
Primary	\$51.00	\$83.00	\$97.00	\$128.00	\$196.00
Primary and Spouse	\$102.00	\$166.00	\$194.00	\$256.00	\$392.00
Primary with 1 Child	\$102.00	\$134.00	\$148.00	\$179.00	\$247.00
Primary with 2 or more Children	\$173.40	\$205.40	\$219.40	\$250.40	\$318.40
Primary and Spouse with 1 Child	\$153.00	\$217.00	\$245.00	\$307.00	\$443.00
Primary and Spouse with 2 or more Children	\$232.05	\$296.05	\$324.05	\$386.05	\$522.05
HEALTH ACCESS PLAN C MONTHLY RATES					
AGE	0-17	18-30	31-40	41-50	51-63
Primary	\$65.00	\$104.00	\$118.00	\$154.00	\$234.00
Primary and Spouse	\$130.00	\$208.00	\$236.00	\$308.00	\$468.00
Primary with 1 Child	\$130.00	\$169.00	\$183.00	\$219.00	\$299.00
Primary with 2 or more Children	\$221.00	\$260.00	\$274.00	\$310.00	\$390.00
Primary and Spouse with 1 Child	\$195.00	\$273.00	\$301.00	\$373.00	\$533.00
Primary and Spouse with 2 or more Children	\$295.75	\$373.75	\$401.75	\$473.75	\$633.75

**You have other options! You can choose:**

Add these optional benefits to customize your coverage.

OPTIONAL BENEFIT	Health Access Plan B	Health Access Plan C
Dental-Vision Discount Plan	\$9.95 for entire family	\$9.95 for entire family
Optional Rehabilitative and Habilitative Therapies For Children Benefit*	\$20.00 per child	\$20.00 per child

\* Calculate the optional benefit rate by multiplying the per child cost by the number of children on the application.

CALCULATE YOUR TOTAL PREMIUM	
Health Access Plan B or C monthly rate	
Dental-Vision Discount Plan rate (if selected)	+
Optional Rehabilitative and Habilitative Therapies For Children Benefit (if selected)*	+
$\frac{\text{amount from table}}{\text{number of children}} \times \text{number of children} =$	
<b>TOTAL MONTHLY PREMIUM</b>	=

**Complete the details below for the Primary applicant:**

PLEASE PRINT

Be sure this name matches the primary applicant's name on the enrollment form, Line 1.

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Last Name First MI Date of Birth State of Residence

**Attention Agents:**

- Be sure the rate sheet is complete and fax it, along with the enrollment form, to 414-299-6020.
- Provide your name and contact information to your client (you can also stamp the back of the brochure).

The rates for this limited-benefit plan are only valid for policies issued with effective dates from December 1, 2008, and later. Rates quoted more than 30 days in advance of the requested effective date are subject to change and are not guaranteed. Issuance of coverage is subject to approval. This proposal is not an insurance contract. Only the actual contract provisions apply. The effective date of the quote does not guarantee coverage and is subject to change. Rates are based on primary's age as of the effective date of the policy. Final rates may vary. All rates are subject to underwriting approval.

Optional Rehabilitative and Habilitative Therapies For Children Benefit (Offer 4648-TX)

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company.

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**OPTIONAL REHABILITATIVE AND HABILITATIVE THERAPIES FOR CHILDREN BENEFIT  
TEXAS RESIDENTS ONLY**

The consideration for this Rider is the additional premium shown in your billing statement. The policy to which this Rider is attached is amended as follows.

The Policy is revised to include Covered Charges for the benefits described below, as elected by the Policyholder in the space provided at the end of this Rider. These benefits are applicable to Texas residents only, and are subject to all other policy terms, limits, and conditions, except to the extent specifically modified by this Rider.

**REHABILITATIVE AND HABILITATIVE THERAPIES**

The following rehabilitative and habilitative therapies provided to a Covered Dependent child with a developmental delay in accordance with an individualized family service plan issued by the Interagency Council on Early Childhood Intervention under Chapter 73 of the Texas Human Resources Code:

1. Occupational therapy evaluations and services.
2. Physical therapy evaluations and services.
3. Speech therapy evaluations and services.
4. Dietary or nutritional evaluations.
5. Professional services of the Health Care Practitioner performing the evaluations and services described in items 1. through 4. above.

The services must be provided in the amount, duration, scope and service setting established in the Covered Dependent child's individualized family service plan. Covered Charges for Inpatient services will be considered in accordance with the Inpatient Hospital Services provision in the Medical Benefits section of the Policy. Covered Charges for Outpatient services will be considered in accordance with the Outpatient Medical Services provision in the Medical Benefits section of the Policy. However, the professional services of the Health Care Practitioner that are Incurred while Outpatient will be considered in accordance with the Office Visit Benefits provision in the Medical Benefits section of the Policy. Covered Charges under the Rehabilitative and Habilitative Therapies provision will not apply to any maximum benefit provided under the Policy. Upon request. You must furnish Us with a copy of the individualized family service plan. This benefit applies only to Covered Dependent children who reside in the State of Texas and have a developmental delay.

- The Policyholder hereby elects the optional coverage of Rehabilitative and Habilitative Therapies provided by this Rider.
- The Policyholder hereby declines the optional coverage of Rehabilitative and Habilitative Therapies provided by this Rider.

\_\_\_\_\_  
Policyholder's Signature

\_\_\_\_\_  
Date

If elected, the Effective Date of this Rider is the Effective Date of the policy to which it is attached.

President

# Health Access Plan B or C Enrollment form for limited benefit health insurance

PLEASE PRINT IN BLACK INK

## PERSON(S) TO BE INSURED

Attach a separate sheet, signed and dated, if additional space is needed below. Label additional dependents starting with the letter "E" and after.

Only complete the spouse and dependent information if it applies.

	Last	Name First	MI	Sex	Birthdate (MM/DD/YY)	
1. Primary						
2. Spouse						
3. Dependents (list relationship below)	Last	Name First	MI	Sex	Birthdate (MM/DD/YY)	Full-time student?
A.						
B.						
C.						
D.						

4. Resident Address: \_\_\_\_\_  
(NO P.O. BOXES) (Street) (City) (State) (ZIP)

5. Phone Number: (\_\_\_\_) \_\_\_\_\_ 6. E-mail Address: \_\_\_\_\_

7. Are any of the proposed insureds covered by, or has application been made for any type of medical insurance?.....  Yes  No  
If "Yes," complete the section below.

Examples of types of coverage are individual medical insurance, group insurance, and supplemental coverage for specific conditions, like cancer.

Proposed Insured's Name	Insurance Company Name	Group or Individual	Type of Coverage	Effective Date (MM/DD/YY)	Termination Date (MM/DD/YY)	Is this coverage being replaced by proposed coverage?

## REQUESTED EFFECTIVE DATE

8. Requested effective date \_\_\_\_\_

Your effective date is based on the date you sign your enrollment form. If you sign it on the 1<sup>st</sup> through the 15<sup>th</sup> of the month, your effective date will be the 1<sup>st</sup> of the following month. If you sign the enrollment form on the 16<sup>th</sup> through the 31<sup>st</sup> of the month, your effective date will be the 15<sup>th</sup> of the following month. Check with your agent for more details.

**FAX ALL PAGES EXCEPT "IMPORTANT NOTICES" TO 414-299-6020**

**HEALTH STATEMENT**

To determine if you're eligible for this individual medical plan, you need to answer a few medical questions for you and anyone else applying for coverage.

*Attach a separate sheet if additional information is needed.  
Date and sign any additional sheets.*

**Note: The plan cannot be issued to any person who answers YES to any of the following questions.**

Enter dependent information in same order as page 1.

		Primary	Spouse			
			A	B	C	D
9. Are you, your spouse, or any person to be insured now pregnant, an expectant parent, in the process of adopting a child or undergoing infertility treatment?	Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> <li>• Heart disorder, excluding Mitral Valve Prolapse (MVP) or surgically corrected or closed Atrial Septal Defect (ASD)/ Ventricular Septal Defect (VSD)</li> <li>• Stroke</li> <li>• Crohn's Disease or Ulcerative Colitis</li> <li>• Liver disorders, excluding fully recovered Hepatitis A</li> <li>• Kidney disorders, excluding kidney stones</li> <li>• Emphysema or Chronic Obstructive Pulmonary Disease (COPD)</li> </ul>		<ul style="list-style-type: none"> <li>• Diabetes, excluding Gestational Diabetes</li> <li>• Basal Cell Carcinoma with recommended surgery that has not been completed</li> <li>• Cancer or Tumor</li> <li>• Alcoholism, Alcohol or Chemical Dependency, or Drug or Alcohol Abuse</li> <li>• Multiple Sclerosis (MS)</li> <li>• Tuberculosis (TB)</li> <li>• Any condition that resulted in Bariatric Surgery</li> </ul>				
11. For any of the following conditions within the last 5 years, have you or any person to be insured tested positive for, or received any medical or surgical treatment or taken medication for:	Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> <li>• Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)</li> </ul>						

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## BILLING

You have four choices for billing. It's important to note we'll request funds as soon as we issue your policy.

We recommend you pick an EFT draft date that is the same as your effective date.

The accountholder's signature is needed here if requesting EFT.

You have two options if choosing to pay by credit card – recurring or 1<sup>st</sup> payment only.

The cardholder's signature is needed here if requesting to pay by credit card.

Please complete this if your billing address is different than your home address.

You have four billing methods to choose from:

### 1. Monthly payroll deduction (list bill)

- Assigned list bill number, if known: \_\_\_\_\_  
*Note to agent: this option requires the employer have a List Bill agreement on file.*

### 2. Monthly Electronic Funds Transfer (EFT)/Check-O-Matic

- To begin withdrawals:  
Select a desired withdrawal date 1-28: \_\_\_\_\_  
Bank name: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_  
Routing number: \_\_\_\_\_  
Account number: \_\_\_\_\_

Jane Doe  
1234 Any Street  
Anytown, US 12345 1234

DATE \_\_\_\_\_

PAY TO THE ORDER OF \_\_\_\_\_ \$ \_\_\_\_\_ DOLLARS

ANYTOWN BANK

MEMO \_\_\_\_\_

123456789 0987654321 1234

Routing Number Account Number  
9 digits

- To add this policy to an existing EFT

Existing EFT number \_\_\_\_\_  
Associated policy number: \_\_\_\_\_

### Authorization for EFT – please sign 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.

Accountholder signature: \_\_\_\_\_ Date: \_\_\_\_\_

- ### 3. Credit card
- Choose how often:  Quarterly  Semi-Annual  Annual  
or  
→  Charge first payment only\*

*\*You must also select a secondary billing method for subsequent payments.  
Once you choose below, go to that section and complete.*

Choose method:  Monthly EFT  Bill me directly

### Authorization for credit card payments – please sign below

I authorize Time Insurance Company to charge my account for the individual medical policy. I understand there will be no refund of premium after the 10-day free look in the contract.

Card number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Card type:  MasterCard  VISA

Expiration date: \_\_\_\_/\_\_\_\_

Name as it appears on card: \_\_\_\_\_

Address of cardholder, if different: \_\_\_\_\_

Cardholder signature: \_\_\_\_\_ Date: \_\_\_\_\_

- ### 4. Bill me directly:
- Choose how often:  Quarterly  Semi-Annual  Annual

If your billing address is different than your home address, please enter it here:

Billing Address: \_\_\_\_\_  
(Street) (City) (State) (ZIP)

Name of person paying, if different: \_\_\_\_\_

FAX ALL PAGES EXCEPT "IMPORTANT NOTICES" TO 414-299-6020

**INDIVIDUAL LIMITED PLAN:  
NON-EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT**

By checking "yes" here, you agree that the insurance you're applying for will not be paid for by an employer.

You understand and agree that you are applying for individual limited benefit health insurance for you (and your family). You further understand that this application for health insurance will be medically underwritten, and is subject to eligibility requirements and that coverage is not guaranteed. You are personally paying the entire premium for this health insurance coverage. Your employer is not contributing in any way to the payment of premium, either directly or indirectly.

Do you agree with this statement? . . . . .  Yes     No

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**AUTHORIZATION**

Signatures are needed in this section. It's important to note you are applying for limited benefit health insurance. Coverage comes with a 10-day free look.

My enrollment form, recorded Authorizations, recorded personal health history and any amendments shall be the basis for the contract.

I understand the insurance coverage is subject to underwriting. The insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company. The effective date is assigned by Time Insurance Company. The first full premium must be paid. A change in the health of the proposed insured(s) after the completion of the enrollment form and before the delivery of the contract may affect my eligibility for insurance with the company. 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.

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

I acknowledge receiving the notification regarding the Abbreviated Notice of Insurance Information Practices and the Outline of Coverage for Health Insurance, if required.

I acknowledge that I have read the completed enrollment form. I attest that all statements and answers on this enrollment form are complete, true and correct. I understand and acknowledge that any fraudulent statement or intentional misrepresentation of material fact on the enrollment form, recorded Authorizations, recorded personal health history 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.

I understand that the coverage offered provides LIMITED BENEFITS and has specific benefit limitations.

\_\_\_\_\_  
Signature of Primary Proposed Insured

\_\_\_\_\_  
Signature of Spouse or Other (if proposed to be insured)

\_\_\_\_\_  
Signature(s) of Other Dependent(s) 18 or Over (if proposed to be insured)

\_\_\_\_\_  
Guardian's Signature

Premium Amount Sent: \$ \_\_\_\_\_

\_\_\_\_\_  
Date and Time signed (including a.m./p.m.)

\_\_\_\_\_  
City and State signed in

Attention: (Agent)

I have reviewed this enrollment form 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.

\_\_\_\_\_  
Licensed Resident Agent's Signature

\_\_\_\_\_  
Print Agent's Name

\_\_\_\_\_ Initial here if you witnessed the signing of this form by the proposed insured.

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**ARE YOU AN EXISTING CUSTOMER?**

Policy # \_\_\_\_\_

What do you want to do?

- Add Dependent
- Policy/Benefit Change to an existing policy  
*List type of change requested:* \_\_\_\_\_
- Reinstatement of Coverage
- Internal Replacement
- Conversion (over-age dependent/divorce)

**AGENT/AGENCY INFORMATION**

Agent Name: \_\_\_\_\_

Agent Number: \_\_\_\_\_

Key Agency Contact: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Agency Name: \_\_\_\_\_

Agency Number: \_\_\_\_\_

You don't need to do anything here. Your agent will complete this section.

**FAX ALL PAGES EXCEPT "IMPORTANT NOTICES" TO 414-299-6020**

**IMPORTANT NOTICES – LEAVE WITH CUSTOMER**

These additional notices provide you with more information on your rights, and fraud and privacy. Keep this sheet for your records.

**ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES**

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances 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.

**FRAUD NOTICE**

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.

**PRIVACY**

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on enrollment forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.

**LEAVE THIS PAGE WITH THE CUSTOMER - DO NOT FAX**