



Assurant Affordable Health AccessSM

Only a few medical questions to qualify

Thank you for applying for a Health AccessSM plan. It's important you understand the benefits and limitations of these limited-benefit fixed-indemnity plans — plans that pay a set amount when you receive particular services. Please review the product brochure and talk with your agent to make sure this type of plan is right for you.

Follow these steps to enroll now!

1. **Decide whom you want to cover** — just you, you and your spouse, just your children, or your entire family. If more than one adult is applying, choose the youngest adult as the primary applicant.
2. **Decide if you want additional coverage** — you'll find value in:
 - **SuiteSolutions®** — help pay out-of-pocket health expenses by purchasing an upgrade to the basic Health Advocates Alliance membership. (You must join Health Advocates Alliance in order to upgrade to the SuiteSolutions membership level — see Rate Sheet for details.)
 - **Assurant Supplemental Coverage** — ask your agent if Accident, Critical Illness and Dental coverage are available in your state.
3. **Calculate your total premium** — transfer the monthly rate/fee from your choices to the calculation table to determine your total monthly premium.
4. **Start the enrollment process for your plan** — please note there is a non-refundable \$25 processing fee.
5. **For quick approval, fully complete the enrollment form and optional benefit elections with your agent, including:**
 - All required questions
 - Requested effective date (must be the 1st or 15th of the month; see enrollment form for details)
 - Signatures for all applicants age 18 and older (child-only policies need a custodial parent or guardian signature)
 - Form 15416-TX (*Notice to Applicant Regarding Replacement of Accident and Sickness Insurance*) if you are replacing your current group or individual medical coverage with this Assurant Affordable Health Access plan

Important notice:

Assurant Health does not use or collect genetic information for any underwriting purpose. Genetic information includes information related to genetic tests, genetic counseling and any family history of a disease or disorder. Any such information should not be included on an application or communicated to Assurant Health in any manner.

You are required to disclose information regarding any disease or condition for which you or any person applying for coverage has:

- been diagnosed with, sought consultation for or been treated for by any healthcare provider,
- had testing with abnormal results or
- taken any prescription medication

Please note that no benefits are provided for any medical events that occur between the date this enrollment form is signed and the effective date of the plan. Additionally, the plan does not pay benefits for events that result from or are related to a pre-existing condition, or its complication(s), until the covered person has been continuously insured for 12 months following the effective date.

Agent: please leave this sheet with your client.



*Applies to plans issued with effective dates
October 1, 2010, and later*

Get quick pricing information on Health Access plans by choosing from the options listed below. For the rates and optional coverage, **circle** the monthly rate and then **copy** the numbers into the **CALCULATE YOUR TOTAL PREMIUM** box on page 2.

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

Complete the details below for the primary applicant:

PLEASE PRINT

Last Name (please print) First Name (please print) MI Date of Birth State of Residence

Attention agents: Be sure the Rate Sheet is complete and fax **all pages**, along with the enrollment form, to 414.299.6020. Provide your name and contact information to your client (you also can stamp the back of the brochure).

1. Choose who will apply for this plan and the age of the primary applicant:

Circle the monthly premium rate.

If more than one adult is applying, choose the youngest adult as the primary applicant. For child-only plans, the youngest is the primary applicant.

HEALTH ACCESS MONTHLY RATES					
AGE	0-17	18-30	31-40	41-50	51-63
Primary	\$89.00	\$109.00	\$119.00	\$159.00	\$249.00
Primary and Spouse	\$178.00	\$218.00	\$238.00	\$318.00	\$498.00
Primary with 1 child	\$178.00	\$198.00	\$208.00	\$248.00	\$338.00
Primary with 2 or more children	\$303.00	\$323.00	\$333.00	\$373.00	\$463.00
Primary and Spouse with 1 child	\$267.00	\$307.00	\$327.00	\$407.00	\$587.00
Primary and Spouse with 2 or more children	\$405.00	\$445.00	\$465.00	\$545.00	\$725.00

See page 2 for additional options and to calculate your premium.

This Rate Sheet is for use with product brochures and state variations which contain details of Health Access Plans and the optional benefits.

The rates for this limited-benefit fixed-indemnity plan are only valid for plans issued with effective dates October 1, 2010, 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 applicant's age as of the effective date of the plan. Final rates may vary. All rates are subject to underwriting approval.

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

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Assurant Affordable Health Access enrollment form for hospital confinement and surgical fixed indemnity insurance plan

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

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

4. Resident Address: _____
(NO PO BOXES) (Street) (City) (State) (ZIP)

5. Phone Number: (____) _____ 6. E-mail Address: _____

7a. 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.

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?

7b. Work Number: (____) _____

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 1st through the 15th of the month, your effective date will be the 1st of the following month. If you sign the enrollment form on the 16th through the 31st of the month, your effective date will be the 15th 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 hospital confinement and surgical fixed indemnity insurance plan, you need to answer a few medical questions for you and anyone else applying for this plan.

*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"/>	<input type="checkbox"/>
	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you, your spouse or any person to be insured totally and permanently disabled and/or receiving long-term disability benefits?	Yes	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
11. 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"/>	<input type="checkbox"/>
	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> • Heart disorder, excluding Mitral Valve Prolapse (MVP) or surgically corrected or closed Atrial Septal Defect (ASD)/ Ventricular Septal Defect (VSD) • Stroke or Brain Aneurysm • Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD) • Crohn's Disease or Ulcerative Colitis • Liver disorders, excluding fully recovered Hepatitis A • Kidney disorders, excluding kidney stones • Emphysema, Chronic Obstructive Pulmonary Disease (COPD), Fibrotic Lung Disease or Primary Pulmonary Hypertension 	<ul style="list-style-type: none"> • Diabetes, excluding Gestational Diabetes • Basal Cell Carcinoma with recommended surgery that has not been completed • Cancer or Tumor • Alcoholism, Alcohol or Chemical Dependency or Drug or Alcohol Abuse • Multiple Sclerosis (MS) • Tuberculosis (TB) • Any condition that resulted in a surgery or procedure whose purpose is to promote weight-loss • Autism Spectrum Disorders, Autism, Asperger's Disorder, Rett's Syndrome, Pervasive Developmental Disorders or Pervasive Developmental Delay 						
12. 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"/>	<input type="checkbox"/>
	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> • Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) 							

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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 a an Electronic Funds Transfer (EFT)/Check-O-Matic draft date that is the same as your effective date.

The accountholder's signature is needed here if requesting Electronic Funds Transfer (EFT) /Check-O-Matic.

You have two options if choosing to pay by credit card – recurring or 1st 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:

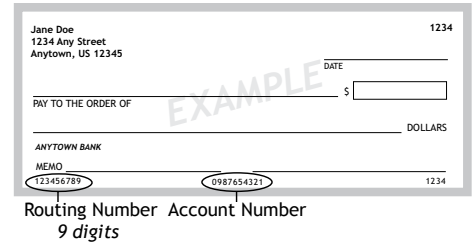
1. Monthly payroll deduction (list bill)

→ 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: _____



→ To add this policy to an existing Electronic Funds Transfer (EFT)/Check-O-Matic

Existing Electronic Funds Transfer (EFT)/Check-O-Matic number: _____
Associated policy number: _____

Authorization for Electronic Funds Transfer (EFT)/Check-O-Matic – 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, 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 other than payroll deduction (list bill) for subsequent payments. Once you choose below, go to that section and complete.*

Choose method: Payroll deduction (list bill)
 Monthly Electronic Funds Transfer (EFT)/Check-O-Matic
 Bill me directly

Authorization for credit card payments – please sign below
I authorize Time Insurance Company to charge my account for the hospital confinement and surgical fixed indemnity insurance plan. 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: _____

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LIFE INSURANCE

Complete this section to designate a beneficiary for life insurance.

Beneficiary for Primary Insured: _____
(Full Name) *(Relationship)*

Contingent Beneficiary: _____
(Full Name) *(Relationship)*

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

**HOSPITAL CONFINEMENT AND SURGICAL FIXED INDEMNITY PLAN
NON-EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT**

You understand and agree that you are applying for a hospital confinement and surgical fixed indemnity insurance plan for you (and your family). You further understand that this enrollment form will be medically underwritten, and that eligibility for this plan is not guaranteed. You are personally paying the entire premium for this plan. Your employer is not contributing in any way to the payment of premium, either directly or indirectly.

Do you agree with these statements? Yes No

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Signatures are needed in this section. It's important to note you are applying for a hospital confinement and surgical fixed indemnity insurance plan. This plan comes with a 10-day free look.

AUTHORIZATION

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

I understand the insurance plan 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 enrollment process may be shared with persons necessary to facilitate issuing this plan, 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.

In order to determine my (our) eligibility for insurance, I hereby authorize any health care provider or medically related facility, pharmacy, pharmacy benefit manager or pharmacy related facility, MIB, Inc., consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information including information regarding employment, other insurance coverage, personal information, medical or pharmacy care, advice, treatment, or medication use as may be requested to Time Insurance Company (or any consumer reporting agency authorized by Time Insurance Company), its legal representative or any medical records retrieval service Time Insurance Company may engage, including, but not limited to, Examination Management Services, Inc. (EMSI), and its agents.

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, Human Immunodeficiency Virus (HIV) testing and treatment, sexually transmitted disease (STD) testing and treatment, sickle cell testing and treatment, prescription history, lab data and electrocardiograms (EKGs). This information may also be disclosed to MIB, Inc. and any medical records company engaged by Time Insurance Company, 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 Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations.

I understand that this authorization is required in order to enable Time Insurance Company to make eligibility or enrollment determinations relating to me and/or my minor children or for Time Insurance Company's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for enrollment.

I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, P.O. Box 3050, Milwaukee, WI 53201-3050. Such revocation will not be valid if Time Insurance Company 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: 30 days after denial of my application, or declination of enrollment, or, if insured, 30 days after when I am no longer an insured of Time Insurance Company. But in no event will this authorization be in effect for longer than 24 months from the date signed.

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

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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 plan I am applying for is a fixed indemnity benefit plan and has specific benefit limitations. This plan is not major medical insurance coverage or a Medicare Supplement Plan.

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: \$ _____

One-time Processing Fee Sent*: \$ _____
*Not applicable in all states

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 this plan
- 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.

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

IMPORTANT NOTICES – LEAVE WITH CUSTOMER

NOTIFICATION REGARDING MIB, Inc. (“MIB”) formerly known as the Medical Information Bureau

Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of the information in MIB’s file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB’s information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Time Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

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

Name of Applicant _____
Please Print

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by TIME INSURANCE COMPANY. For your own information and protection, you should be aware of and seriously consider certain facts which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still 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/health history. Failure to include all material medical information on any application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

Applicant's Signature

Date

**PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS
PLEASE FAX TO: 414-299-6020**

**IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE, ACCIDENT,
HEALTH AND HOSPITAL SERVICE INSURANCE GUARANTY ASSOCIATION**
(For insurers declared insolvent or impaired on or after September 1, 2005)

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association (the "Association"), to protect Texas policyholders if their life or health insurance company fails. Only the policyholders of insurance companies which are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the Texas Insurance Code, Chapter 463.)

It is possible that the Association may not cover your policy in full or in part due to statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas at that time (irrespective of the policyholder's residency at policy issue)
- Residents of other states, ONLY if the following conditions are met:
 1. The policyholder has a policy with a company domiciled in Texas;
 2. The policyholder's state of residence has a similar guaranty association; and
 3. The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of \$500,000 for basic hospital, medical-surgical, and major medical insurance, \$300,000 for disability or long term care insurance, and \$200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of \$100,000 under one or more policies on any one life; or
- Death benefits up to a total of \$300,000 under one or more policies on any one life; or
- Total benefits up to a total of \$5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of \$100,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of \$100,000 on any one life; or
- Present value of unallocated benefits up to a total of \$5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- \$300,000 on any one life with the exception of the \$500,000 health insurance limit, the \$5,000,000 multiple owner life insurance limit, and the \$5,000,000 unallocated group annuity limit.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are electing an insurance company, you should not rely on Association coverage.

Texas Life, Accident, Health and Hospital
Service Insurance Guaranty Association
6504 Bridge Point Parkway, Suite 450
Austin, Texas 78730
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or
www.tdi.state.tx.us