AMERICAN COMMUNITY
MUTUAL INSURANCE COMPANY®
39201 Seven Mile Road, Livonia, Michigan 48152-1094

IL Application
for Non-Renewable Short Term Medical Expense Policy

For Home Office Use Only
Policy No. ____________

For applicants less than 64 years of age. If children are to be insured, include all children, stepchildren and children adopted or placed for adoption of the applicant, who are dependent on the applicant and at least 15 days old, but have not reached their 22nd birthday.
PLEASE PRINT IN BLACK INK.

Key Applicant Full Name	Sex	Date of Birth	Social Security Number
Spouse	Sex	Date of Birth	Social Security Number
Dependent	Sex	Date of Birth	Social Security Number
Dependent	Sex	Date of Birth	Social Security Number
Dependent	Sex	Date of Birth	Social Security Number
Resident Address			
City, State, Zip Code			County
Resident Phone Numbers Daytime: ( )	Evening: ( )	**REQUESTED EFFECTIVE DATE** ☐ Day After Postmark	☐ Specific Date ____/____/____

QUESTIONS APPLY TO EACH PERSON PROPOSED FOR INSURANCE. IF ANY OF THE FOLLOWING QUESTIONS ARE ANSWERED "YES", SUCH PERSON IS INELIGIBLE FOR THE POLICY. If "yes", who:

1. Have you, or any person to be insured, lived in a country outside the United States within the past 12 months? ☐ Yes ☐ No ____________
2. Is any person to be insured now pregnant, an expectant father or planning to adopt a child during the term of this policy? ☐ Yes ☐ No ____________
3. Has any person to be insured been recommended to seek treatment or do they have symptoms or conditions for which they intend to seek medical advice? ☐ Yes ☐ No ____________
4. Has anyone to be insured had a Blood Pressure reading that exceeded 140/90 in the past 12 months? ☐ Yes ☐ No ____________
5. Within the last five years, have you, your spouse or any dependent to be insured, sought advice, been diagnosed or received any medical treatment for the following: ☐ Yes ☐ No ____________
   - Heart disorder (such as chest pain, heart attack, irregular heart beat)
   - Chronic respiratory conditions
   - Blood disorders
   - Central nervous system disorders
   - Stroke
   - Liver disorder
   - Kidney disorder
   - Diabetes
   - Rheumatoid arthritis
   - HIV/AIDS
   - Hepatitis
   - Cancer or tumors
   - Alcohol, drug, or chemical abuse or dependency

I have read this application and represent that the information shown on it is true and complete to the best of my knowledge and belief. I understand and agree that:

1. The effective date of coverage can be no earlier than the day after the postmark date or, if not mailed, the date after the application is received at the Home Office of American Community Mutual Insurance Company.
2. No benefits are payable for a pre-existing condition as described in the policy.
3. Each person named in questions 1 through 5 is excluded from coverage under this policy.
4. No other Hospital, Major Medical, Group Health, or Medical Insurance coverage is in force on the effective date of this coverage.
5. The policy I am applying for is not a renewal or extension of any previous coverage and does NOT cover any condition for which benefits were paid under a previous policy.
6. I acknowledge that I have been provided with a Notice of Your Privacy Rights.
7. I have received a copy of the Outline of Coverage for the policy.

THIS IS LIMITED COVERAGE. PRE-EXISTING CONDITIONS ARE NOT COVERED. ALTERED APPLICATIONS WILL NOT BE ACCEPTED.

X ______________________________ ____________ X______________________________ ____________

Signature Key Applicant (or if minor Child, Parent or Guardian) — Date — **Spouse's Signature** — Date

AGENT INFORMATION: Name: ______________________________ Number:____________________

Phone #______________ Fax #______________ **Signature: X**______________________________

FRAUD WARNING: Any person, who with intent to defraud, or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. Any false statement or misrepresentation may result in the loss of coverage under this policy.

ACCIDENTAL DEATH & DISMEMBERMENT BENEFICIARY (If no beneficiary is listed, the benefit will default to your estate. Benefits for loss of life of your spouse, if covered under the certificate, will be paid to you.)

Primary Beneficiary ______________________________ Relationship ____________________

Contingent Beneficiary ______________________________ Relationship ____________________

INITIAL PREMIUM PAYMENT OPTIONS: (make check or money order payable to American Community Mutual Insurance Company)

$____________ ☐ Credit Card ☐ Check ☐ Money Order

INITIAL PREMIUM SHORTAGE OPTIONS:

☐ Credit Card Please complete Credit Card information if you have selected it as a Premium Payment Option.

CREDIT CARD (for initial payment only)

☐ **MasterCard** Card Holder Name:______________________________

☐ **Visa** Card Number: ______________________________ Expiration Date: ____________________

Signature: X ______________________________ Date signed: ____________________

BILLING MODE:

☐ Monthly ☐ Lump Sum

BILLING OPTIONS:

☐ Bill Me ☐ EFT (Electronic Fund Transfer)

ELECTRONIC FUNDS TRANSFER (EFT)

☐ Checking

☐ Savings

Returned Check Fee: If any premium payment made directly by check or by Electronic Funds Transfer (EFT) is returned for non-sufficient funds, a nonrefundable service fee will be charged.

Name of Financial Institution: ______________________________

Address:______________ City: ______________ State: ______Zip Code: ____________

Account Holder's Name:______________________________

Transit Routing Number: ______________________________ Account Number:____________________

Authorization Agreement For Electronic Funds Transfer for Premium Payment

I authorize American Community Mutual Insurance Company (Company) to initiate monthly electronic withdrawals, in the amount of the then-current monthly premium rate, from the account and financial institution (Bank) named above. This authority remains in effect until Company and Bank receives written notification from me of its termination in such time and manner as to give Company and Bank a reasonable opportunity to act on it. Company reserves the right to void this agreement at any time without prior notice.

Signature: X ______________________________ Date Signed:____________________

RATES EFFECTIVE SEPTEMBER 1, 2007. Rates subject to change for policies issued with effective dates of September 1, 2008 and after.

1 80/20 BENEFIT PERCENTAGE

Age	$250 Ded. M	$250 Ded. F	$500 Ded. M	$500 Ded. F	$1,000 Ded. M	$1,000 Ded. F	$2,500 Ded. M	$2,500 Ded. F
18-24	81	109	62	84	48	67	35	49
25-29	87	114	67	88	55	72	38	50
30-34	98	130	76	100	60	81	43	57
35-39	114	141	88	108	71	88	52	64
40-44	143	168	110	129	88	101	64	74
45-49	186	199	143	153	112	120	82	87
50-54	234	228	180	175	143	138	104	101
55-59	299	263	230	202	186	158	136	115
60-63	375	297	288	228	230	182	169	133
Child	52	52	38	38	28	28	18	18

1 50/50 BENEFIT PERCENTAGE

Age	$250 Ded. M	$250 Ded. F	$500 Ded. M	$500 Ded. F	$1,000 Ded. M	$1,000 Ded. F	$2,500 Ded. M	$2,500 Ded. F
18-24	61	82	47	63	36	50	26	37
25-29	65	86	50	66	41	54	29	38
30-34	74	98	57	75	45	61	32	43
35-39	86	106	66	81	53	66	39	48
40-44	107	126	83	97	66	76	48	56
45-49	140	149	107	115	84	90	62	65
50-54	176	171	135	131	107	104	78	76
55-59	224	197	173	152	140	119	102	86
60-63	281	223	216	171	173	137	127	100
Child	39	39	29	29	21	21	14	14

2 COUNTY	AREA FACTOR
Cook, Dupage, Lake	1.16
DeKalb, Grundy, Kane, Kankakee, Kendall, LaSalle, Madison, McHenry, St. Clair, Will	1.10
Rest of State	1.00

PLAN CHOSEN:

Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $2,500 **Coinsurance:** ☐ 80/20 of $5,000 ☐ 50/50 of $5,000

TERM OF INSURANCE:

☐ 1 Month ☐ 2 Months ☐ 3 Months ☐ 4 Months ☐ 5 Months ☐ 6 Months

PREMIUM CALCULATIONS: (figure health premium at age last birthday.)

	Male		Female		Child/Children		Total
1 Base Rate	______	+	______	+	______	=	______
					2 Area Factor	x	______
						=	______
					3 Premium Mode	x	______
					Monthly Premium	=	______

All key applicants under the age of 18 will pay the male age 18-24 rate. Dependents age 18 or older pay adult rates. Dependent children ages 15 days through 17 years pay the child rate for the first 3 children. No charge for additional children under age 18.

To calculate EFT or monthly payment options, multiply the monthly premium by the modal factor. To calculate the lump sum payment, multiply the monthly premium by the number of months of coverage.

3 PREMIUM MODES	MODAL FACTOR
Lump Sum Payment	1.00
Electronic Funds Transfer (EFT)	1.05
Monthly Payment Premium	1.10

We know that your trust in us is very important. We are committed to protecting your privacy rights. Please read this document carefully. It discloses your privacy rights.

Obtaining Information About You — We may obtain information from your application, a telephone interview with you, claims history with us, policies you have or had with us, account balances and premium payment history, and other sources, such as health care providers (medical information), and consumer reporting agencies (credit reports). Your address, birthday, telephone number, social security number are examples of such information. An investigative consumer report may be prepared where information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted to obtain information as to your character, general reputation and personal characteristics. You may have to share such information with us, our affiliates, agencies or others working with us.

Our Use of Personal Information — We will share such information only with companies associated with us. We, or your agent or broker may use your information to offer you products or help you choose a product. We may, as permitted by the law and without your prior approval, give information about you to persons who do business for us, your agent or broker, other insurance companies, or other persons handling your business, insurance company support organizations, regulatory or law enforcement authorities; and our affiliated companies. Information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons.

YOUR RIGHTS

- The right to access, inspect and copy the personal information pertaining to you that we maintain in our files about you.
- The right to request that we correct or amend any personal information that we have about you.
- To request an interview in connection with the preparation of an investigative consumer report.

To exercise these rights, please send a written request to the attention of the Privacy Coordinator.

How We Protect Your Personal Information — We protect the information we share with companies working for us through an agreement. The agreement obligates those companies to keep your information confidential.

Only our employees who work to service your business see your personal information. We have trained our employees to closely follow our privacy rules for your protection. Your privacy rights will continue if you cease to be our customer.

THE REMAINDER OF THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required to maintain the privacy of your personal medical information and provide you with this notice as to our legal duties and privacy practices. We are required to abide by the terms of this notice. We reserve the right to change the terms of this notice and to make any new provisions effective to all of the medical information that we maintain about you. If we revise this notice, we will provide you with a revised notice by mailing the revised notice to the address you have supplied us.

STATEMENT OF YOUR RIGHTS

You have the right to know how we use or disclose your personal medical information. There are certain uses and disclosures of your personal medical information that we are permitted or required to make by law without your permission. In addition, you have:

- The right to request that we place additional restrictions on our uses and disclosures of your personal medical information, but we are not obligated to agree to any such restrictions.
- The right to access, inspect and copy the protected information pertaining to you that we maintain in our files, and the right to request that we correct or amend any personal medical information that we have about you.
- The right to receive an accounting of the disclosures of your personal medical information that we make for purposes other than activities related to your treatment, or our payment functions or other health care operations.
- The right to request that you receive communications of personal medical information in a confidential manner.
- The right to obtain a paper copy of this notice from us on request.

To exercise these rights please send a written request to the attention of the Privacy Coordinator.

PERMISSIBLE USES AND DISCLOSURES OF PROTECTED MEDICAL INFORMATION

Payment Functions. We may use or disclose your protected medical information without your permission to carry out activities relating to reimbursing you for the provision of health care, obtaining premiums, determining coverage, and providing benefits under the policy of insurance that you are purchasing. For example, payment functions may include (but are not limited to) reviewing health care services with respect to medical necessity, coverage under the policy, appropriateness of care, or justification of charges.

Health Care Operations. We may also use or disclose your protected medical information without your permission to carry out certain insurance-related activities. For example, these activities include using your protected information for underwriting, premium rating, or other activities relating to the creation, renewal or replacement of another contract of health insurance, placing a contract for reinsurance of risk relating to claims for health care, and performing audit functions to ensure compliance and proper claims payment.

Group Health Plan. We may disclose your protected medical information to your employer as necessary for the purpose of reporting claims experience or conducting an audit if you are covered under an employer-based group health insurance plan.

Business Associates. We may disclose your protected medical information to our business associates. There are some services provided in our company through contracts with our business associates.

Uses Permitted By Law. We may also use or disclose your protected medical information without your written permission for purposes permitted or required by law.

Authorized Uses. All other disclosures of your protected medical information will be made only with your written permission, and any permission that you give us may be revoked by you at any time.

COMPLAINTS ABOUT MISUSE OF INFORMATION — If you believe your privacy rights have been violated you may complain either directly to us or to the Secretary of Health and Human Services (H.H.S.). Please submit all complaints in writing and to us or H.H.S. as follows:

American Community Mutual Insurance Company
Attn: Privacy Officer
39201 Seven Mile Road
Livonia, MI 48152-1094

U.S. Department of Health and Human Services
Attn: Secretary
200 Independence Ave S.W.
Washington, DC 20201

You will not be retaliated against in any way for filing a complaint.

OBTAINING FURTHER INFORMATION — Please call us if you have any questions or comments. The phone number is (800) 991-2642.

Effective Date: April 14, 2003