AMERICAN COMMUNITY
MUTUAL INSURANCE COMPANY®

Thank you for your interest in American Community Individual health insurance.

To complete this form electronically, you will need to save it to your computer:

1. From the **File** menu, choose **Save As…** .
2. Save the file to your computer. You may change the file name.

To complete this form by hand, perform the following steps:

1. From the **File** menu, click **Print**. Remember to make a copy of your completed application for your files before mailing it.

You are now ready to complete the form electronically or print the application and complete it by hand.

Tips for Completing the Application Electronically

1. The application will automatically save itself each time you move to a new page. However, you should still save your work frequently.
2. To tell where the data-entry fields are on the application, click Preferences from the Edit menu. In the Categories list, click Forms. Place a checkmark in the Show border hover color for fields checkbox. The field highlighting will not print on your document.
3. Certain fields that are duplicated throughout the application are "lookup" fields; this information will be automatically inserted into all duplicate entries throughout the document (for example, the Key Applicant name will automatically be entered in every field where it is required throughout the document).
4. You will need to create a digital signature for each applicant required to sign the application **if you choose to submit your application electronically**. When you click on a digital signature field for the first time, Adobe Reader will begin a digital signature wizard to assist you in creating an electronic signature. After a signature has been created on your computer, the system will prompt you to use the existing signature. For more assistance on creating digital signatures, review the guide titled, "Working with Digital Signatures."

Please be sure to review your application for accuracy and completeness before you submit it to prevent delays in processing.

You may submit the application via one of the following methods:

If you completed the application electronically:

- Submit the application to American Community through our secure website. Click the **E-mail American Community** button found on the Privacy Rights page to navigate to this webpage.
- E-mail the application to your American Community agent. Click the **E-mail Agent** button found on the Privacy Rights page to open your default e-mail program. Note: This is not a secure way to send personal information.
- Print the application and submit it to American Community by fax or mail.

If you completed the application by hand:

- Fax it to American Community at (734) 853-3117.
- Mail it to: American Community Mutual Insurance Company
  39201 Seven Mile Rd.
  Livonia, Michigan 48152
  Attn: New Business

Once your application has been processed, you will receive a confirmation from American Community via the United States Postal System to your home address. Please allow up to five business days to receive your confirmation.

If you have any questions, please contact your American Community agent or review our Frequently Asked Questions.

Need Help?

AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY®

Nebraska Product Selection Form

for the Individual Health Insurance Application

Product Selection

Please mark appropriate deductible, coinsurance and optional benefit(s) for product selected.

Key Applicant_____

PPO Network: ❑ Midlands Choice

❑ Next Generation HSA

Coinsurance (Network/Non-Network)	❑ **100%/75%**	❑ **80%/50%**	
Deductible (Network/Non-Network) These deductible options meet the 2009 requirements for qualified high-deductible health plans. The network and non-network deductibles are separate and charges incurred under one deductible will not be applied to the other deductible.	❑ **Individual (Plan Year)**	❑ **Common Family (Plan Year)**	❑ **Embedded Family (Plan Year)**
	❑ $1,150*/$2,300*	❑ $2,300*/$4,600*	
	❑ $1,500/$3,000	❑ $3,000/$6,000	
	❑ $2,100*/$4,200*	❑ $4,200*/$8,400*	❑ $4,600*/$9,200*
	❑ $2,700*/$5,400*	❑ $5,450*/$10,900*	❑ $5,450*/$10,900*
	❑ $3,500/$7,000	❑ $7,000/$14,000	❑ $7,000/$14,000
	❑ $5,000**/$10,000**	❑ $10,000**/$20,000**	❑ $10,000**/$20,000**
	** These may be adjusted annually for changes in the U.S. Consumer Price Index (CPI)* *** Not available on 80%/50% Coinsurance*		
Optional Benefits	❑ Dental ❑ Maternity		
HSA Fund Administration	❑ **American Chartered Bank** (No fee - By selecting this option you will be required to contact American Chartered Bank to set up your Health Savings Account (HSA).) ❑ **HealthEquity** ($3.95 monthly fee - By selecting HealthEquity, I hereby open a Health Savings Account (HSA) with HealthEquity serving as Custodian and agree to the terms of the HealthEquity Custodial Agreement, which is available online at www.healthequity.com and will be sent to me in the mail. There is no additional set up required.) ❑ **Other/None**		

❑ **Community Flex**	**Flex 100**	**Flex 80**	**Flex 60**
Individual Coinsurance (Network/Non-Network)	❑ 100%/70% of $10,000	❑ 80% of $10,000/ 50% of $10,000	❑ 60% of $10,000/ 50% of $20,000
		❑ 80% of $20,000/ 50% of $20,000	❑ 60% of $20,000/ 50% of $20,000
Individual Deductible (Network/Non-Network) The network and non-network deductibles are separate and charges incurred under one deductible will not be applied to the other deductible.	❑ $5,000/$10,000	❑ $1,000/$2,000	❑ $500/1,000
	❑ $7,500/$15,000	❑ $1,500/$3,000	❑ $1,000/$2,000
	❑ $10,000/$20,000	❑ $2,500/$5,000	❑ $1,500/$3,000
		❑ $3,500//$7,000	❑ $2,500/$5,000
		❑ $5,000/$10,000	❑ $3,500//$7,000
		❑ $7,500/$15,000	❑ $5,000/$10,000
			❑ $7,500/$15,000
Prescription Drugs Choose one option if additional Rx coverage is desired.	❑ Generic ($0 deductible)	❑ Four-Tier ($250 deductible)	
Optional Benefits	❑ Gold Benefits	❑ Dental	

Accidental Death & Dismemberment Beneficiary - For Next Generation HSA and Community Flex only
(If no beneficiary is listed, the benefit will default to your estate)

Beneficiary_____ Relationship _____

Need Help?

AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY®

Nebraska Product Selection Form

for the Individual Health Insurance Application

Product Selection

Please mark appropriate deductible, coinsurance and optional benefit(s) for product selected.

Key Applicant_____

PPO Network: ❑ Midlands Choice

❑ **Triple Tier**	**Copay/Deductible (Calendar Year)**		**Coinsurance (Tier I/Tier II/Tier III)**	
	Network	Non-Network	Network	Non-Network
❑ Plan 1	$40/$1,000	$80/$2,000	100%/90%/70%	50%/50%/50%
❑ Plan 2	$50/$3,000	$100/$6,000	100%/90%/70%	50%/50%/50%
Optional Benefits	❑ Dental ❑ Maternity			

Accidental Death & Dismemberment Beneficiary - For Next Generation HSA and Community Flex only
(If no beneficiary is listed, the benefit will default to your estate)

Beneficiary_____ Relationship _____

Need Help?

Nebraska
Application for Individual Health Insurance Policies

Please complete application in blue or black ink.

AMERICAN COMMUNITY
MUTUAL INSURANCE COMPANY®
39201 Seven Mile Road, Livonia, Michigan 48152-1094
(800) 991-2642 (734) 591-9000
www.american-community.com

Thank you for applying to American Community Mutual Insurance Company (*herein referred to as American Community or AC*). Please take the time to carefully complete this application. Your answers will become part of the underwriting process and the insurance contract.

A. TYPE OF APPLICATION

☐ New Application ☐ Change to a new policy with AC. Current Policy #_____

☐ Add Dependents to Policy # _____ Key Insured _____

(Please indicate information only on the dependents to be added to the policy.)

• Was an American Community Short Term application submitted with this application? ☐ Yes ☐ No

B. PERSONS APPLYING FOR INSURANCE

1. **List all Family Members applying for insurance.** Children must be at least 15 days old and under 22 years old. Include maiden names of females in parentheses. To qualify as a full time (FT) student (for children between the ages of 18 and 22), a child must be enrolled in a minimum of 12 credit hours at a college, university, or trade school. (If additional space is needed to list your children, please attach an additional page.)

Full Name First-Middle-Last (Include Maiden Name if used within past 5 yrs.)	Relationship to Applicant	Sex M/F	Date of Birth	Height FT. IN.	Weight LBS.	Social Security Number	✓ if FT Student
	Key Applicant						
	Spouse						
	Child						
	Child						
	Child						

2. Home Address

Street		
City	State NE	Zip
County		

3. Billing Address if other than Home Address

Name		
Street		
City	State	Zip

4. If any proposed applicant does not live at the above address, please explain: _____

5. Contact Numbers

Daytime Ph. #
Evening Ph. #
Spouse's Ph. #
Email Address

6. Occupation(s) If self-employed, please identify or describe your occupation.

Key Applicant Occupation:
Spouse Occupation:

You may be contacted for a telephone interview.

Please indicate the best time (between 8:00 a.m. and 5:00 p.m. Eastern Standard Time) for an interview: _____

C. EXISTING COVERAGE AND REPLACEMENT

Are any Applicants covered by other health insurance now? ☐ Yes - Complete section below ☐ No

Will this coverage be replaced by this policy if issued? ☐ Yes ☐ No - **Desired effective date:**_____

Applicant(s) Name(s)	Insurance Company Name	Group or Individual	Certificate or Policy Number	Effective Date	Termination Date

D. BENEFITS REQUESTED

Please complete and attach the Nebraska Product Selection Form identifying the Health Plan selected.

Need Help?

E. PREMIUM PAYMENT INFORMATION

Estimated monthly premium quoted by agent $ _____

INITIAL PREMIUM PAYMENT OPTIONS: (make checks payable to American Community Mutual Insurance Company)

☐ Credit Card ☐ Check $ _____ ☐ EFT (Only if EFT is chosen as the billing option)

INITIAL PREMIUM SHORTAGE OPTIONS:

☐ Credit Card ☐ Bill Me ☐ EFT (Only if EFT is chosen as the billing option)

Please complete Credit Card and/or EFT information if you have selected them as a Premium Payment Option.

CREDIT CARD FOR INITIAL PAYMENT
(Includes credit card convenience fee of $5.25)

☐ **Discover**
☐ **MasterCard**
☐ **Visa**

Card Holder Name: _____

Card Number: _____ Expiration Date: _____

Signature: X _____ Date signed: _____

BILLING FREQUENCY:

☐ Monthly ☐ Quarterly* ☐ Semi-Annually* ☐ Annually*

BILLING OPTIONS:

☐ Bill Me** ☐ EFT (Electronic Fund Transfer)

☐ New List Bill** (List Bill Agreement Required) ☐ List Bill #_____

Employer name for List Bill_____

*Not available if EFT or List Bill is chosen as billing option.

**Administrative Charge: Once approved, an additional Billing Fee of $10 will be applied to each premium statement (fee is waived for EFT). List Bills include a $25 Monthly Billing Fee.

ELECTRONIC FUNDS TRANSFER (EFT)

☐ Checking
☐ Savings
(If allowed by bank)

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 receive 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: _____

Signature: X _____ Date Signed: _____

F. QUESTIONS APPLY TO EACH PERSON APPLYING FOR COVERAGE (APPLICANTS)

Please answer all questions.

	Yes	No
1. Are you, your spouse, significant other, or any dependent or adopted child now pregnant or is there an adoption pending? **If yes, Do Not Submit Application.**	☐	☐
2. Are you a U.S. Citizen?	☐	☐
Has any applicant lived outside the United States within the past 12 months or does any applicant plan to travel outside the United States in the next 12 months? If yes, who? _____ Where?_____ When? (give date range) _____	☐	☐
3. Has any applicant smoked cigarettes, cigars, pipes or used any form of tobacco, including chewing tobacco or nicotine products? If yes, who? _____ Form of tobacco used: _____ Number of years used:_____ How often did or do you use tobacco products? (ex. 10 cigarettes per day.) _____ If quit, please provide date of last use:_____ Why did you quit?_____	☐	☐
4. Does any applicant engage in scuba or sky diving, organized racing, flying or other hazardous activities? If yes, who? _____ What activity?_____	☐	☐
5. Did or does any applicant consume, on average, more than 2 alcoholic beverages *(one beverage equals one 12 oz. beer or one 4 oz. wine or 1 oz. of liquor)* per day in the past 5 years? If yes, please complete the Alcohol/Drug Questionnaire.	☐	☐
6. Has any applicant's driver's license been suspended or revoked in the last 5 years? If yes, please provide their name and driver's license number. Name:_____ Driver's license number: _____ If yes, and alcohol or drugs were related to suspension/revocation, please complete Alcohol/Drug Questionnaire.	☐	☐

(continued on next page)

Need Help?

(Section F continued)

Within the last 10 years, has any applicant had symptoms of; or a diagnosis of; or received treatment, including but not limited to medications for; or had testing for; or consulted with a physician or medical professional concerning:

Answer each question (please do not draw a continuous line through your answers) and document details of any "Yes" answers on page 4.

		Yes	No
7.	Abdominal Pain	☐	☐
8.	Abnormal test results	☐	☐
9.	Adrenal Gland Disorders	☐	☐
10.	Alcohol Abuse	☐	☐
11.	Allergies	☐	☐
12.	Alzheimer's	☐	☐
13.	Anemia	☐	☐
14.	Aneurysm	☐	☐
15.	Anxiety	☐	☐
16.	Arthritis/gout	☐	☐
17.	Artificial limb or prosthesis	☐	☐
18.	Asthma	☐	☐
19.	Autism	☐	☐
20.	Autoimmune Disorders	☐	☐
21.	Back or spine Disorder	☐	☐
22.	Bladder Disorders	☐	☐
23.	Blood Disorders	☐	☐
24.	Breast Disorder	☐	☐
25.	Bronchitis	☐	☐
26.	Cancer	☐	☐
27.	Carpal Tunnel Syndrome	☐	☐
28.	Cerebral Palsy	☐	☐
29.	Cesarean Section	☐	☐
30.	Chest Pain	☐	☐
31.	Chronic fatigue syndrome	☐	☐
32.	Chronic infections	☐	☐
33.	Chronic Obstructive Pulmonary Disease (COPD)	☐	☐
34.	Colitis	☐	☐
35.	Colon polyps	☐	☐
36.	Convulsions	☐	☐
37.	Crohn's Disease	☐	☐
38.	Cyst	☐	☐
39.	Depression	☐	☐
40.	Diabetes or High Blood Sugar	☐	☐
41.	Digestive Disorders	☐	☐
42.	Drug Abuse	☐	☐
43.	Ear Infections	☐	☐
44.	Eating Disorders	☐	☐

		Yes	No
45.	Edema	☐	☐
46.	Elevated cholesterol (>250)	☐	☐
47.	Elevated Triglycerides (>300)	☐	☐
48.	Emphysema	☐	☐
49.	Epilepsy	☐	☐
50.	Eye Disorders	☐	☐
51.	Female Disorders	☐	☐
52.	Fibromyalgia	☐	☐
53.	Foot Disorder	☐	☐
54.	Gallbladder Disorder	☐	☐
55.	Gastric bypass	☐	☐
56.	Gastric reflux	☐	☐
57.	Headaches	☐	☐
58.	Hearing Impairment	☐	☐
59.	Heart attack	☐	☐
60.	Heart Disorders	☐	☐
61.	Heart murmur	☐	☐
62.	Hemophilia	☐	☐
63.	Hemorrhoids	☐	☐
64.	Hernia	☐	☐
65.	High Blood Pressure (provide last 3 pressures and dates)	☐	☐
66.	Hodgkin's Disease	☐	☐
67.	Infertility	☐	☐
68.	Intestinal Disorder	☐	☐
69.	Irregular heartbeat	☐	☐
70.	Irritable bowel syndrome	☐	☐
71.	Joint Disorders/ Replacement	☐	☐
72.	Kidney Disorders	☐	☐
73.	Knee Disorder/injury	☐	☐
74.	Leukemia	☐	☐
75.	Liver Disorder	☐	☐
76.	Lou Gehrig's Disease	☐	☐
77.	Lupus	☐	☐
78.	Lyme Disease	☐	☐
79.	Lymphadenopathy	☐	☐
80.	Lymphoma	☐	☐
81.	Male Genital Disorder	☐	☐

		Yes	No
82.	Mental And Nervous Disorders	☐	☐
83.	Migraines	☐	☐
84.	Miscarriage	☐	☐
85.	Multiple sclerosis	☐	☐
86.	Muscular Disorders	☐	☐
87.	Muscular dystrophy	☐	☐
88.	Nervous System Disorders	☐	☐
89.	Numbness or tingling	☐	☐
90.	Osteoporosis or Osteopenia	☐	☐
91.	Pancreas Disorders	☐	☐
92.	Paralysis	☐	☐
93.	Phlebitis	☐	☐
94.	Pneumonia	☐	☐
95.	Polyp	☐	☐
96.	Pregnancy Complications	☐	☐
97.	Prostate Disorders	☐	☐
98.	Rectal bleeding	☐	☐
99.	Reproductive System Disorders	☐	☐
100.	Respiratory Disorders	☐	☐
101.	Seizures	☐	☐
102.	Shoulder Disorder/Injury	☐	☐
103.	Sinus infections	☐	☐
104.	Skin condition	☐	☐
105.	Sleep Disorders	☐	☐
106.	Speech Impairment	☐	☐
107.	Stroke	☐	☐
108.	Substance Abuse	☐	☐
109.	Thyroid Disorder	☐	☐
110.	TemporoMandibular Joint (TMJ)	☐	☐
111.	Tonsils	☐	☐
112.	Transient Ischemic Attack (TIA)	☐	☐
113.	Tremors	☐	☐
114.	Tumor	☐	☐
115.	Ulcer	☐	☐
116.	Varicose veins	☐	☐
117.	Vertigo or Dizziness	☐	☐

Has anyone applying for coverage (Document details of any "Yes" answers on page 4

		Yes	No
118.	Been diagnosed or treated for any medical symptom or condition not listed above?	☐	☐
119.	Had any diagnostic testing, treatment, or surgery recommended or scheduled that has not been completed?	☐	☐
120.	Had any symptoms or conditions for which a prudent person would seek medical advice or treatment?	☐	☐
121.	Taken, or currently take, any medication?	☐	☐
122.	Had Breast Implants or Internal Fixation (plates, screws, pins, shunts, stents, etc.)?	☐	☐
123.	Had a routine medical exam or routine PAP Smear or well child exam?	☐	☐
124.	Been tested positive for, been diagnosed as having, or been treated for:		
	a. Human Immunodeficiency Virus (HIV)?	☐	☐
	b. Hepatitis?	☐	☐
	c. Sexually transmitted disease?	☐	☐

Note: Benefits will be paid for a sickness, injury or condition that existed prior to the effective date of this policy, if approved, only if such sickness, injury, or condition is fully disclosed on this application and is not excluded from coverage by a rider or policy exclusion.

If any questions or conditions in section F are checked "Yes", please explain below (use additional paper, if necessary).
Please indicate all details of the symptoms, injury, ailment or condition. Include items such as specific location of condition, diagnosis, type of treatment, testing, and/or hospitalization.

Question Number	Patient/Applicant	Condition, Injury, Symptom, or Diagnosis			Was recovery complete?	Treatment or advice given, surgery performed, diagnostic test results and medications prescribed	Name, address and phone number of doctors and hospitals
		Condition	Date began	Date last treated			

PLEASE INCLUDE ANY DOCTOR/FACILITY LISTED ABOVE ON THE AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION. FAILURE TO LIST COMPLETE ADDRESSES AND PHONE NUMBERS OF DOCTORS/FACILITIES CAN RESULT IN DELAYED UNDERWRITING.

Additional Information:

G. CONSENT, TERMS AND CONDITIONS

1. I represent that I have read this Application and understand each of the questions, and that the answers to each of the questions I have given are complete and true to the best of my knowledge. I agree that any misrepresentation on this Application will void my policy at the discretion of American Community. I further agree that if a policy is issued, it will be issued by American Community in full reliance and in consideration of the information, answers and statements contained herein. I understand that this application will be medically underwritten. I agree to provide American Community with any additional information that may be necessary to complete the underwriting process.
2. No contract, waiver, modification or change of contract shall be binding upon American Community unless it is in writing and signed by an authorized officer of American Community.
3. I represent that neither I, nor my spouse, is receiving any form of reimbursement or compensation for this coverage from any employer.
4. I understand and agree that no agent or broker has the authority: (i) to bind American Community by making promises regarding eligibility, benefits, or the issuance of a policy; (ii) to waive any answer or any portion of any answer to any question on this application or any information American Community requests; (iii) approve coverage; (iv) make or alter any contract on behalf of American Community; or (v) waive or alter any of American Community's other rights or requirements.
5. I consent to any consumer reporting agency that has any record, public record or knowledge of the character, general reputation, personal characteristics, mode of living or type of risk of any persons proposed for insurance to give to American Community, its legal representatives or its reinsurers, any such record or knowledge for purposes of underwriting insurance. This includes, but is not limited to, motor vehicle driving records and criminal history.
6. I consent to any physician, hospital, clinic, pharmacy, or other medical or medically related facility and insurance company, health information repository, its agents, business associates, or legal representatives to give to American Community, its legal representatives or its reinsurers any information or records or knowledge of the health, except for psychotherapy notes, of any persons proposed for insurance to carry out treatment, payment and health care operations.
7. An unaltered copy of this authorization is as valid as the original for 30 months from the date signed. I know that I, or my authorized representative, may request and are entitled to receive a copy of the consent.
8. I am signing this application on my own behalf and on behalf of all listed dependents. I understand that my statements and answers in this application must continue to be true as of the date I receive the policy. I understand that if my or my dependent's health or any of the answers or statements change prior to delivery of the policy, I must inform American Community in writing. I understand that failure to do so may result in my application being denied or rescission of my or my dependent's coverage under the policy.
9. I understand that, unless required by law, the completion of this application and submission of any estimated initial premium does not: a.) provide interim coverage, b.) guarantee coverage, or c.) guarantee issue of a policy.

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

WARNING: Any person who, with intent to defraud or knowing that he or she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Do not cancel any current health insurance coverage until you receive an approval letter and an insurance policy from American Community. You will be notified of the effective date of your policy.

PROXY

The undersigned hereby appoints the President of American Community Mutual Insurance Company, with full power of substitution as the undersigned's proxy with full power, to vote and act on their behalf on all issues at all meetings of the members of the Company and any adjournments thereof. If the proxy named herein, or his named substitute, is for any reason unable to act, the Board of Directors of the Company may fill the place of such proxy by appointing another. The proxy named herein shall only vote for those persons to serve as directors who have been nominated by the Board of Directors of the Company. If such persons are unable or unwilling to serve, then the proxies named herein may select other nominees and vote for such other nominees to serve as directors. In addition, all other matters properly brought before the meeting of the members the proxy will vote in accord with the recommendation of the Board of Directors, if any, and, if none, according to his judgment. This proxy will continue in force for the period of time the undersigned is the named insured of a policy issued and in effect by the Company. The proxy may be revoked by the undersigned at any time by filing with the Secretary of the Company a written revocation, a duly executed proxy bearing a later date or by attending and voting in person at any meeting of the members.

X _____	_____
Signature	Date

AGENT INFORMATION: Name: _____ Number: _____

Phone # _____ Fax # _____ **Signature: X** _____

H. AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION:

In order to comply with HIPAA privacy regulations and other privacy laws, I authorize any physician, medical professional, hospital, clinic, pharmacy, or other medical or medically related facility, insurance company, health information repository, medical record retrieval service as well as those entities listed below, and their agents, business associates and/or legal representatives to give to American Community Mutual Insurance Company, its legal representatives or its reinsures, any protected health information including medical records, lab work, x-rays, consultation reports, or knowledge of the health of the undersigned for underwriting purposes. This authorization also includes confidential communicable disease related information, confidential HIV-related information, and information about drug and alcohol use. This authorization permits disclosure of medical documents for 5 years prior to the date signed. This authorization includes all health related information except psychotherapy notes.

1. _____
Key Applicant's Name — Physician/Facility, Address and Phone Number

2. _____
Spouse's Name — Physician/Facility, Address and Phone Number

3. _____
Child's Name — Physician/Facility, Address and Phone Number

4. _____
Child's Name — Physician/Facility, Address and Phone Number

5. _____
Child's Name — Physician/Facility, Address and Phone Number

This authorization is valid for 30 months from the date below. A photographic copy of this authorization shall be as valid as the original for 30 months from the date below.

I understand and acknowledge that:

1. Execution of this authorization is required for eligibility and enrollment onto this plan. Failure to execute this authorization will result in denial of my application for enrollment.
2. I have the right to revoke this authorization by notifying American Community in writing, except to the extent that American Community has taken action in reliance on this authorization.
3. American Community must comply with federal privacy laws when using or disclosing health information. There may be times when the health information may be disclosed to another entity and the health information may no longer be protected by federal privacy laws, and may be disclosed by that entity. Examples of the types of entities not subject to federal privacy laws include, but are not limited to, business associates American Community uses to administer its benefits, regulators, and law enforcement officials.
4. If there are specific state laws regarding specific health conditions for which we cannot use this form to obtain health information about you, we will ask you to sign a state specific authorization form.

1. **X** _____
Signature of key applicant* — Date — Social Security Number — Date of Birth

2. **X** _____
Signature of spouse* — Date — Social Security Number — Date of Birth

3. **X** _____
Signature of dependent (age 18 and over)* — Date — Child's name — Child's Social Security Number — Date of Birth

4. **X** _____
Signature of dependent (age 18 and over)* — Date — Child's name — Child's Social Security Number — Date of Birth

5. **X** _____
Signature of dependent (age 18 and over)* — Date — Child's name — Child's Social Security Number — Date of Birth

*If under the age of 18, the parent or guardian must sign on the child's behalf and indicate their relationship next to their signature. If you are the individual's representative and are not the parent of a minor, you must attach documentary evidence of your authority to act as the individual's representative for this authorization to be valid.

Applicant MUST keep a copy of this authorization form and send a signed copy in with the application.

Need Help?

NOTICE OF YOUR PRIVACY RIGHTS

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

U.S. Department of Health and Human Services (H.H.S.)
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 American Community at (800) 991-2642 if you have any questions or comments.

Effective: April 14, 2003

Email AMERICAN COMMUNITY

Email AGENT

Need Help?

AMERICAN COMMUNITY
MUTUAL INSURANCE COMPANY

This page may be used to provide additional information related to the application.

If additional information has been included, the Key Applicant must sign and date this page:

X_____ _____

Signature Key Applicant Date