



# Application *Packet*

Indiana

*Have you:*

- ✓ *Signed all forms necessary for health insurance application?*
- ✓ *Answered all applicable questions?*
- ✓ *Selected a method of payment and enclosed a voided check, if you selected Automatic Bank Draft?*



# MEMBER APPLICATION TO TAXPAYERS NETWORK INC.



## New/Existing Member Information — Name of Member Paying Dues

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

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

If existing member, dues paid through: \_\_\_\_\_

Please enroll me as a member of Taxpayers Network Inc. (If I am not an existing member, the information I've provided will complete my TNI enrollment.)

→ **Signature Required:**

Tear Here

Taxpayers Network Inc. is a membership association recognized by the IRS as a 501(c)(4) nonprofit organization. Membership dues, contributions or gifts to Taxpayers Network Inc. are not deductible as charitable contributions for federal income tax purposes. Membership dues for Taxpayers Network Inc. are \$7 per month (\$84 per year). Members receive the educational newsletter Taxpayers Network Quarterly including coupons redeemable for booklets and paperbacks on selected important public issues. Members also receive a valuable package of benefits, discounts and options. Membership dues are subject to change without notice.

# Indiana Member Application for Group Insurance



New Business       Change in Benefits (specify requested date below in Coverage Information section)       Dependent Add

This application is to be completed by the applicant applying for coverage. For child only, application is to be completed by the child's parent or legal guardian if child is not of legal age.

**Applicant's Social Security Number** \_\_\_\_\_ **Group No.** (Home Office to assign) \_\_\_\_\_

## APPLICANT/PERSON TO BE COVERED FOR CHILD ONLY

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_  
 Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_  
 (PO Box, not acceptable)  
 Billing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone No. (\_\_\_\_\_) \_\_\_\_\_ Best time to Call \_\_\_\_\_ Alternate Phone No. (if applicable) (\_\_\_\_\_) \_\_\_\_\_  
 Gender  M  F Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  Single  Married  
 Primary Care Physician's Name \_\_\_\_\_

**Applicant's Occupation:** \_\_\_\_\_ **Spouse's Occupation:** \_\_\_\_\_

Beneficiary's Name (The beneficiary listed below is for applicable products only)

Last \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_ Relationship \_\_\_\_\_

Yes  No Are you a U.S. citizen? If no, list how long in the U.S.: \_\_\_\_\_ (Attach copy of valid permanent resident card)

## DEPENDENT ENROLLMENT INFORMATION

(If more space is needed, attach an additional sheet of paper, sign and date it.)

**Spouse** (First Name & M.I., last name if different): \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Gender  M  F Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Primary Care Physician's Name \_\_\_\_\_

**Child** (First Name & M.I., last name if different): \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Gender  M  F Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Primary Care Physician's Name \_\_\_\_\_

**Child** (First Name & M.I., last name if different): \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Gender  M  F Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Primary Care Physician's Name \_\_\_\_\_

**Child** (First Name & M.I., last name if different): \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Gender  M  F Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Primary Care Physician's Name \_\_\_\_\_

Dependents (age 19 up to 25) attending school full-time, include name of dependent, name/address of school, and number of credits: \_\_\_\_\_

## ELIGIBILITY

Yes  No Are you or any family members covered by Medicare/Medicaid? If yes, list family members and their effective date: \_\_\_\_\_

Yes  No Are you, any family member, or significant other pregnant or in the process of adoption or surrogacy (including those not applying for coverage)? \_\_\_\_\_

Yes  No Are you or any eligible dependent disabled, receiving disability payments, or hospital confined? \_\_\_\_\_

## COVERAGE INFORMATION

## OPTIONAL BENEFITS

**Medical:**       Applicant       Applicant/Family       Applicant/Spouse  
                      Applicant/Child(ren)       Child only

**Requested effective date** \_\_\_\_\_ (Effective date may not be guaranteed)

Network Name \_\_\_\_\_ Product Name \_\_\_\_\_

Copay/Deductible \_\_\_\_\_ Coinsurance \_\_\_\_\_

Upon signature of this application, I am indicating that I have selected the plan design within this Coverage Information section and that I fully understand the benefit levels of this plan.

I am a HIPAA Eligible Individual but I choose to apply for the Non-HIPAA Eligible medical plan selected. I understand there is no guarantee of policy issuance and that the pre-existing condition limitations of the selected plan will apply regardless of my status as a HIPAA Eligible Individual.

The HIPAA Eligible guarantee issue plan is the Indiana Comprehensive Health Insurance Association.

Yes  No Supplemental Accident Benefit \_\_\_\_\_

Yes  No Dental Plan \_\_\_\_\_

Yes  No Prescription Drug Buy-up  
 Plan Selected: \_\_\_\_\_

Yes  No Term Life/AD&D Insurance

Yes  No Dependent Life

Yes  No Optional Term Life/AD&D Insurance

(\$10,000 min.-\$300,000 max.)

Indicate amount: \_\_\_\_\_

**Home Office Use Only**

Depending upon state law, this information may be used in determining whether your application is approved for coverage.

## MEDICAL HISTORY

A. Within the past five years, has any person to be insured ever had any diagnosis, consultation, routine follow-up, treatment, or therapy; been prescribed any medication; been monitored; or received counseling for any of the following?... (Provide details to "Yes" answers below.)

<p><b>1) Digestive Disorder</b></p> <p>a. Irritable Bowel, Spastic Colon <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Colitis, Crohn's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Gastric Reflux, Heartburn <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Gallbladder Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e. Hepatitis, Other Liver Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f. Other Digestive or Intestinal Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>6) Genitourinary</b></p> <p>a. Fibrocystic Breast, Implants, Other Breast Condition <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Ovarian Cyst, Uterine Fibroid <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Infertility Testing or Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Menstrual, Reproductive Organ Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e. Abnormal Pap Smear <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f. Prostate Gland Disorder, Abnormal PSA Test <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>g. Sexually Transmitted Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>h. Urinary Tract, Bladder, Kidney Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>10) Psychological</b></p> <p>a. Anxiety, Panic Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Depression, Major Depressive Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Bipolar Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Obsessive Compulsive Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e. Schizophrenia, Schizoaffective Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f. Anorexia, Bulimia Nervosa <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>g. Other Psychological Condition <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>11) Neurological</b></p> <p>a. Cerebral Palsy, Muscular Dystrophy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Epilepsy, Seizures, Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Headaches, Migraines <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Mental Retardation, Down's Syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e. Multiple Sclerosis, Paralysis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f. Other Neurological Disease or Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>g. Alzheimer's Disease, Dementia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>h. Parkinson's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>i. Autism, Pervasive Develop. Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>2) Cardiovascular/Circulatory</b></p> <p>a. High Blood Pressure, Hypertension <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Mitral Valve Prolapse, Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Chest Pain, Heart Attack, Arrhythmia, Angina, Palpitations <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Vascular Abnormality, Poor Circulation <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e. Stroke, Transient Ischemic Attack <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f. Other Heart Condition or Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>7) Eyes/Ears/Nose/Throat/Skin</b></p> <p>a. Acne, Skin Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Ear, Nose, Sinus, Throat, Mouth <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Eye, Cataracts, Glaucoma, Other <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Loss of Hearing, Deafness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e. Jaw Condition or TMJ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f. Vision Impairment, Blindness <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>12) General</b></p> <p>a. Abnormal Test Results <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Burns <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Congenital Abnormality, Loss of Limb <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Edema <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e. Fibromyalgia, Chronic Fatigue <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f. Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>g. Organ or Tissue Transplant <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>h. Pain Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>i. Surgical Implants <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>j. Chronic Infection <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>k. Ulcer <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>13) Other</b></p> <p>a. Health disorders not listed above <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>3) Respiratory/Lung</b></p> <p>a. Allergies, Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Bronchitis, COPD, Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Sleep Apnea, Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Other Respiratory or Lung Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>8) Endocrine/Gland/Lymph/Blood</b></p> <p>a. Blood Abnormality, Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Elevated Cholesterol/Triglycerides <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Diabetes, Pancreas, Elevated Glucose <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Hormonal Disorder, Adrenal <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e. Lymph Gland Disorder, Immune System <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f. Thyroid, Goiter <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
<p><b>4) Musculoskeletal/Nerve</b></p> <p>a. Arthritis or Rheumatism, Carpal Tunnel <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Neck, Back, Spinal Condition <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Bone, Muscles, Joint Condition <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Fracture, Dislocation, Internal Fixation <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e. Lupus, Connective Tissue Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f. Osteoporosis, Osteopenia <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>9) Alcohol/Drug</b></p> <p>a. Alcoholism, Alcohol Use (3+ drinks/day) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Drug or Substance Abuse, Illicit Use <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
<p><b>5) Cyst/Tumor/Polyp/Malignancy</b></p> <p>a. Cancer, Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Cyst, Growth, Lump, Tumor, Polyp <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Hodgkin's or Non-Hodgkin's Lymphoma <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			

- B.  Yes  No Have you or any eligible dependent ever been declined, postponed, rideded, rescinded, or rated up for medical, disability, critical illness, life insurance, or long term care with another insurance carrier? If yes, explain: \_\_\_\_\_
- C.  Yes  No In the past five years, have you or any person to be insured received treatment or therapy by a health care provider, taken medication prescribed by a health care provider, or consulted a health care provider for any health concern(s)? If yes, explain: \_\_\_\_\_
- D.  Yes  No Are you or any person to be insured currently taking any prescription medication, over-the-counter medication, vitamin therapy or alternative remedies (including herbs)? Please indicate the reason for use: \_\_\_\_\_
- E.  Yes  No In the past five years, have you or any person to be insured been advised by a health care provider to have a test or treatment, been advised by a health care provider to obtain equipment or service or been advised by a health care provider of a health condition or diagnosis that may require attention or treatment or are you awaiting the results of any medical tests or investigation? If yes, Explain: \_\_\_\_\_
- F.  Yes  No Within the past five years, has any person to be insured been advised to seek treatment for or been advised to limit alcohol or drug use, been a member of any alcohol or drug abuse support group or used any controlled drug not prescribed by a doctor? If yes, explain: \_\_\_\_\_
- G.  Yes  No Has any person to be insured ever been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex by a physician or member of the medical profession, or tested positive for HIV? If yes, list names: \_\_\_\_\_
- H.  Yes  No Has anyone to be insured used tobacco products during the previous 12 months? If yes, list names: \_\_\_\_\_

Provide details to "YES" answers (If more space is needed, attach an additional sheet of paper, sign and date it.)

Question No./Letter	Name	Illness/Impairment	Dates Treated	Medications/Treatment/Surgery/Physician's Name & Address

## PRIOR COVERAGE

- Yes  No Are you or any dependents replacing health coverage that was in effect within the last 63 days?  
 Yes  No Do you or any dependents to be insured have or intend to keep any health insurance coverage, including COBRA and/or state continuation currently in force?  
 Yes  No Have you or any dependents ever been previously covered by PacifiCare or AMS? If yes, list PacifiCare or AMS ID #: \_\_\_\_\_

**If you answered "Yes" to any of the above questions, please complete the following section. If you answered "No" to all questions, please proceed to the Terms and Conditions of Insurance section.**

Name(s) of covered individual	Insurance Company Name, Address and Phone	Policy or Group Number	Type of Coverage <small>(individual, employer group, short term, COBRA, Medicare, other)</small>	Effective Date	Termination Date

## TERMS AND CONDITIONS OF INSURANCE

You, the Applicant, shall furnish to American Medical Security Life Insurance Company (AMS) any information required for AMS to underwrite and administer the insurance. You shall have records available for AMS to inspect at any time while insurance is in force, and for up to the earlier of three years after the termination date or the final adjustment and settlement of claims is made. AMS reserves the right to waive or change any of the above requirements at any time.

AMS compensates producers for the sale of certain products. You may contact your producer for information regarding the amount or type of compensation paid by AMS.

### AMS UNDERWRITING REQUIREMENTS

You are required to submit this Member Application for Group Insurance (Application) for yourself and/or for all eligible dependents to be insured. **Insurance for any person is not effective until the date specified by AMS.** Depending upon the law, AMS may have the right to decline insurance for any person for whom information has been submitted in this Application. AMS will waive the pre-existing limitation for medical coverage for conditions disclosed on this Application, but AMS may place an exclusion rider on certain condition(s), where permitted.

### TERMINATION OF INSURANCE

You may terminate insurance at any time by providing us written notice prior to the requested termination date. The termination date will be the first of the month following receipt of the request. Insurance will terminate at 12:01 a.m. Central Standard Time on the termination date. AMS will terminate insurance if you fail to pay premium on the due date, except that coverage continues for a grace period of 31 days after the premium due date. You will be responsible to pay premium for the grace period coverage unless, before any premium due date, you provide written notice to AMS of request to cancel. In addition to reasons for termination that are specified in the group insurance policy, AMS may also reform or rescind coverage for fraud or material misrepresentation. When AMS terminates insurance, AMS will provide you with a minimum of 31 days advance written notice of the termination date unless termination is due to nonpayment of premium, fraud or misrepresentation. Termination will not prejudice a valid claim existing on the termination date, unless termination is due to nonpayment of premium, fraud or misrepresentation.

Upon termination, you may request reinstatement of coverage by paying all applicable premium. A nonrefundable reinstatement fee may apply, where allowed by state law. AMS will deposit payment during review of your request. Depositing your check does not mean acceptance and does not guarantee reinstatement. AMS can approve or decline reinstatement requests and will notify you in writing of its decision.

Benefits are not effective until you receive written approval from AMS. No action is taken on this Application until all required information is submitted. The deposit amount will be returned to you if this Application is declined.

### To be a valid application, your signature and the date you sign it are required. Signature Required-Applicant Agreement

I understand that all answers will be relied upon by AMS in the issuance of a certificate of insurance. I declare all statements contained in this entire Application about me and my dependents to be insured are true and correct to the best of my knowledge and that no material information has been withheld or omitted. I understand and agree that AMS is not bound by any statement made by or to any producer unless written herein. I understand that no person other than an officer of AMS has the authority to bind or alter benefits and that any such attempt by any producer is void and is not effective. **I agree that no coverage will be effective until written notification has been provided by AMS and that the actual effective date may not be the requested effective date.**

To assist with determining my creditable coverage, I authorize any insurance company, third-party administrator, plan administrator, pharmacy benefit manager, pharmacy, or other carrier or provider of health benefits to release to AMS certificates of creditable coverage and all such information.

**Any person who, knowingly and with intent to defraud any insurance company, submits an application or files a claim containing any materially false information may be found guilty of insurance fraud, which is a crime, in a court of law and may be subject to fines and confinement in prison. This will not be considered as a complete application unless all pages are attached and completed.**

- I wish to have my certificate of insurance delivered to:  My Producer  Myself
- I hereby acknowledge receipt of the "Notice of Information Practices". I understand that I may request an additional copy at any time.

**SIGNATURES**

- I understand that the policy for medical coverage will not pay benefits during the first 12 months after the effective date for a disease or physical condition I now have or have had in the past that has not been disclosed on this Application.

Applicant's Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

(If for child only, signature must be the child's parent or legal guardian if the child is not of legal age.) \_\_\_\_\_  
(Parent or Legal Guardian Name)

If signed by a representative of Applicant, please indicate the representative's authority to act on behalf of Applicant. \_\_\_\_\_

Spouse's Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

(If spouse is to be covered)

Dependent's Signature (age 18 or older) **X** \_\_\_\_\_ Date \_\_\_\_\_

**PRODUCER INFORMATION**

- I certify that I have delivered the "Notice of Information Practices" to the applicant, as required by law.

Producer Name (if applicable) \_\_\_\_\_ Producer ID \_\_\_\_\_  
(Only last 4 digits required)

Producer Address \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

General Agent Name/Number \_\_\_\_\_

Licensed Producer Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

**SIGNATURE REQUIRED/AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR UNDERWRITING**

**Please clearly print all information.**

I hereby authorize those physicians, medical practitioners, hospitals, clinics, veterans administration facilities, medical information services, such as, but not limited to, the Medical Information Bureau (MIB) and Ingenix, Inc. (Ingenix), urgent care facilities, and other medical or medically related entities, insurance or reinsurance companies, and consumer reporting agencies that have information available as to the present or former physical health condition, including drug or alcohol abuse, and/or treatment of me or my dependents to release any and all such information, including, but not limited to, medical records, health-care provider notes, pharmacy data, laboratory tests and results, diagnoses, treatment, and prognoses, to American Medical Security Life Insurance Company (AMS) or its designee. I further authorize AMS or its designee to disclose such protected health information to medical information services, such as, but not limited to, MIB and Ingenix. I understand the information obtained by use of this authorization may be used to determine eligibility for issuance of health coverage and eligibility for benefits under an existing policy for me and my dependents. This authorization is not applicable to psychotherapy notes.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by AMS or its designee and may no longer be protected by state or federal privacy law.

I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall expire 15 months from the latest signature date below. I understand that I may request a copy of this authorization. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on my authorization. Because this authorization is given as a condition of obtaining coverage, my revocation will not prevent AMS or its designee from the right to contest a claim under the policy if another law so allows. Should my dependents or I refuse to sign this authorization, I understand it may affect my enrollment in the health plan. I understand that all pages must be attached and complete, including this authorization, for this Application to be considered complete and that incomplete applications may be rejected.

Applicant's Signature **X** \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date \_\_\_\_\_

(If for child only, signature must be the child's parent or legal guardian if the child is not of legal age.)

If signed by a representative of Applicant, please indicate the representative's authority to act on behalf of Applicant.

Spouse's Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

(If spouse is covered)

Signature of each covered dependent age 18 and over:

**X** \_\_\_\_\_ Date \_\_\_\_\_ **X** \_\_\_\_\_ Date \_\_\_\_\_

**X** \_\_\_\_\_ Date \_\_\_\_\_ **X** \_\_\_\_\_ Date \_\_\_\_\_

# Payment Authorization Form

## A. APPLICANT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ SS# \_\_\_\_\_

## B. INITIAL METHOD OF PAYMENT

- Check Enclosed       Credit Card (Complete Credit Card Authorization below)

### CREDIT CARD AUTHORIZATION (AVAILABLE FOR FIRST MONTH PAYMENT ONLY)

- VISA       MasterCard

Cardholder's First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_  
(As it appears on credit card)

Cardholder's Address \_\_\_\_\_ Cardholder's Phone Number \_\_\_\_\_

Credit Card Number: \_\_\_\_\_ Verification Code \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
(16 digits required) (3 digits required from back of credit card) (MM/YYYY)

As a convenience, I request and authorize American Medical Security Life Insurance Company (AMS) to charge my credit card account, identified above, for the payment of my health plan premium and any fees for the payment option(s) designated. In submitting this payment authorization with my application, I understand that the initial premium for my health plan may be adjusted based on my medical history (or that of any dependent to be covered) and agree that the additional amount(s) required may be charged to this account. I further agree that should this card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, AMS will attempt to contact me, but shall be under no liability whatsoever, including any fees imposed by the card issuer, even though such dishonor may ultimately result in forfeiture of coverage.

Signature of Credit Cardholder X \_\_\_\_\_ Date \_\_\_\_\_  
(As it appears on credit card)

If the VISA/Mastercard request for payment is declined, a \$25 nonrefundable service fee may be applied when allowed by state law.

**Note: If effective date of coverage is the 15<sup>th</sup> of the month, you may be charged for 1½ months of premium for the initial payment.**

## C. ONGOING METHOD OF PAYMENT

- Automatic Monthly Bank Draft (Complete Bank Draft Authorization below)
- Direct Bill Choose One: (Fees may apply)
- Quarterly       Semi-Annual       Annual       Monthly Direct Bill (Available in CA only)

- List Bill\*

\* Not available in some states, additional forms required

### BANK DRAFT AUTHORIZATION

Type of Account:  Checking       Savings

Account Holder Name \_\_\_\_\_ Financial Institution \_\_\_\_\_  
(As it appears on financial institution records)

Routing/Transit # (9 digits required) \_\_\_\_\_ Account Number (9 digits required) \_\_\_\_\_

I hereby authorize American Medical Security Life Insurance Company (AMS) to initiate debit entries to my account and the financial institution named above. AMS will not be held responsible for policy lapse or cancellation due to nonpayment of premium if the withdrawal is presented and not honored for any reason and the amount due is not paid. This authorization is to remain in full force and effect until AMS has received written notice of my intention to terminate this authorization. I understand that I must give at least 30 days advance notice to terminate or change this authorization. AMS is not responsible for charges I may incur from my bank due to late notification of the termination or change.

Signature of Primary Applicant/Parent or Legal Guardian X \_\_\_\_\_ Date \_\_\_\_\_

Signature of Account Holder X \_\_\_\_\_ Date \_\_\_\_\_  
(If other than Primary Applicant/Parent or Legal Guardian)

If payment is submitted by my employer, I will need to complete a payment disclaimer form, when required and/or permitted by state law.

If the automatic bank draft or direct payment by check transaction is returned for any reason, a \$25 nonrefundable service fee will be applied when allowed by state law.

American Medical Security Life Insurance Company (AMS) 3100 AMS Blvd., P.O. Box 19032, Green Bay, WI 54304-9032, 800-232-5432 underwrites fully insured products and provides administrative services for PacifiCare Life and Health Insurance Company and PacifiCare Life Assurance Company.

(800) 232-5432 • [www.eAMS.com](http://www.eAMS.com)



Insurance products are underwritten by American Medical Security Life Insurance Company,  
a wholly owned subsidiary of PacifiCare Health Systems, LLC.

## NOTICE OF INFORMATION PRACTICES

### NOTICE OF PRIVACY PRACTICES

#### THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We (including our affiliates listed at the end of this notice) are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. The terms "information" or "health information" in this notice include any personal information that is created or received by a health care provider or health plan that relates to your physical or mental health or condition, the provision of health care to you, or the payment for such health care.

We have the right to change our privacy practices. If we do, we will provide the revised notice to you within 60 days by direct mail or post it on our Web sites listed at the bottom of this page.

#### How We Use or Disclose Information

We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative);
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected; and
- Where required by law.

We have the right to use and disclose health information to pay for your health care and operate our business. For example, we may use your health information:

- **For Payment** of premiums due us and to process claims for health care services you receive.
- **For Treatment.** We may disclose health information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business and to help manage your health care coverage. For example, we might conduct or arrange for medical review, legal services, and auditing functions, including fraud and abuse detection or compliance programs.
- **To Provide Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health related products and services.
- **To Plan Sponsors.** If your coverage is through an employer group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restriction on its use and disclosure of the information.

- **For Appointment Reminders.** We may use health information to contact you for appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.
- **For Public Health Activities** such as reporting disease outbreaks.
- **For Reporting Victims of Abuse, Neglect, or Domestic Violence** to government authorities, including a social service or protective service agency.
- **For Health Oversight Activities** such as governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** such as providing limited information to locate a missing person.
- **To Avoid a Serious Threat to Health or Safety** by, for example, disclosing information to public health agencies.

- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and for the protective services for the President and others.
- **For Workers' Compensation** including disclosures required by state workers compensation laws of job-related injuries.
- **For Research Purposes** such as research related to the prevention of disease or disability, if the research study meets all privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information for procurement, banking, or transplantation of organs, eyes, or tissue.

If none of the above reasons apply, **then we must get your written authorization to use or disclose your health information.** If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is our intent to meet the requirements of the more stringent law. In some states, your authorization may also be required for disclosure of your health information. In many states, your authorization may be required in order for us to disclose your highly confidential health information. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based on your authorization. To revoke an authorization, contact the phone number listed on your ID card.

#### What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that may authorize certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with its policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address).
- **You have the right to see and obtain a copy** of health information that may be used to make decisions about you such as claims and case or medical management records. You also may receive a summary of this health information. You must make a written request to inspect and copy your health information. In certain limited circumstances, we may deny your request to inspect and copy your health information.
- **You have the right to ask to amend** information we maintain about you if you believe the health information about you is wrong or incomplete. We will notify you within 30 days if we deny your request and provide a reason for our decision. If we deny your request, you may have a statement of your disagreement added to your health information. We will notify you in writing of any amendments we make at your request. We will provide updates to all parties that have received information from us within the past two years (seven years for support organizations).
- **You have the right to receive an accounting** of disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information: (i) made prior to April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials; and (v) other disclosures that federal law does not require use to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice upon request. In addition, you may obtain a copy of this notice at our Web sites, [www.eAMS.com](http://www.eAMS.com) or [www.goldenrule.com](http://www.goldenrule.com).

#### Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, please call the phone number on your ID card.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the following address: Golden Rule Insurance Company, Privacy Officer, 7440 Woodland Drive, Indianapolis, IN 47278-1719.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. **We will not take any action against you for filing a complaint.**

#### Fair Credit Reporting Act Notice

In some cases, we may ask a consumer-reporting agency to compile an investigative consumer report about you. If we request such a report, we will notify you promptly with the name and address of the agency that will furnish the report. You may request in writing to be interviewed as part of the investigation. The agency may retain a copy of the report. The agency may disclose it to other persons as allowed by the federal Fair Credit Reporting Act.

We may disclose information solely about our transactions or experiences with you or our affiliates.

#### Medical Information Bureau

In conjunction with our membership in the Medical Information Bureau (MIB), we or our reinsurers may make a report of your personal information to MIB. MIB is a nonprofit organization of life and health insurance companies that operates an information exchange on behalf of its members.

If you submit an application or claim for benefits to another MIB member company for life or health insurance company, the MIB, upon request, will supply such company with information regarding you that it has in its file.

If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. Contact MIB at: MIB, Inc., P.O. Box 105, Essex Station, Boston, MA 02112, (866) 692-6901, [www.mib.com](http://www.mib.com) or (TTY) (866) 346-3642.

#### FINANCIAL INFORMATION PRIVACY NOTICE

We (including our affiliates listed at the end of this notice) are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an insured or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms such as name, address, age and social security number, and
- Information about your transactions with us, our affiliates or others, such as premium payment history.

We do not disclose personal financial information about our insureds or former insureds to any third party, except as required or permitted by law.

We restrict access to personal financial information about you to employees, affiliates, and service providers who are involved in administering your health care coverage or providing services to you. We maintain physical, electronic, and procedural safeguards that comply with federal standards to guard your personal financial information.

We may disclose personal financial information to financial institutions which perform services for us. These services may include marketing our products or services or joint marketing of financial products or services.

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The Notice of Information Practices, effective January 2007, is provided on behalf of American Medical Security Life Insurance Company, Golden Rule Insurance Company, PacifiCare Life and Health Insurance Company, PacifiCare Life Assurance Company, All Savers Insurance Company, and UnitedHealthcare, Inc.

To obtain an authorization to release your personal information to another party, please go to the appropriate Web site listed at the bottom of the page.



## Indiana Disclosure Notice

*This disclosure notice is only a summary. The company's Certificate of Group Insurance (Certificate) or evidence of coverage should be consulted to determine governing contractual provisions.*

### **The Insurer's Structure**

American Medical Security Life Insurance Company is a Wisconsin stock life and accident health insurer licensed to do business in 40 states and the District of Columbia.

### **Description of Covered Services and Network Restrictions**

Covered services include, but are not limited to, doctor services, hospital and other facility charges, home health care, mammography, emergency services, ambulance services, sick baby care, skilled nursing care, transplants, hospice care, wellness services, and child health supervision. You may visit any provider as defined by the Certificate. However, if you choose a plan using a network, you may reduce out-of-pocket costs by using an eligible network provider. Always contact us before receiving services to verify that your provider is contracted with your network because network providers continually change.

### **Access to Services**

If you choose a plan using a preferred provider network, you have several ways to find out if a doctor, health-care provider, or facility is part of your network. You may:

- Call us at (800) 232-5432, select 2 and listen for additional options. This number is listed on your identification card.
- Visit the Provider Section of the AMS Web site at [www.eAMS.com](http://www.eAMS.com). All networks may not be available online at this time.
- Ask your provider.

### **Network Financial Incentives and Disincentives**

Our plans do not use compensation programs that include incentives or penalties intended to encourage network providers to withhold services or minimize or avoid referral to a specialist. Network providers are not required by your plan to comply with any specified numbers, targeted averages, or maximum duration of patient visits.

### **Limitations of Payment**

Benefits are payable subject to plan limitations. Benefits are payable only for a covered expense that is medically necessary as defined by the health insurance plan. Benefits are not payable when the pre-existing condition limitation applies or for covered expenses that exceed the maximum allowable charge.

If an insured has selected a plan using the UnitedHealthcare Choice Plus network, and care is received from a network provider, the provider is responsible for notifying us regarding an inpatient admission or specific planned procedure. When care is received from a non-network provider, the insured is responsible for notifying us. Notification may not guarantee coverage or payment for services or procedures reviewed.

For all other networks, we require notification of a hospital confinement and for certain other types of medical services for most plans. These are only general limitations. See the Certificate for a general description of the plan limitations.

### **Exclusions from Coverage**

For coverage exclusions please refer to the Certificate.

### **Terms are defined below.**

***Covered Expense*** means a medical service that is:

1. Incurred while you or your insured dependent is insured by the plan;
2. Prescribed, ordered, recommended, or approved by an authorized health-care provider;
3. Medically necessary;
4. Not subject to an applicable limitation or exclusion; and
5. Allowed under all other applicable terms and conditions of the Certificate or in a Rider that is attached to the Certificate.

We will not pay for that part of a covered expense that:

1. Is subject to a copayment, deductible, coinsurance, or penalty; or
2. Exceeds an applicable benefit maximum.

***Maximum Allowable Charge*** means the maximum benefit amount we will pay for each covered expense. This amount is based on our predetermined methodology, which is either:

1. A calculation based on an independently published database; or
2. An amount based on the following:
  - a. The type of medical service;
  - b. The geographic area where the medical service is provided; and
  - c. Other applicable related factors.

The methodology may be updated by us on a periodic basis as we deem appropriate.

You or your insured dependent may be responsible to pay a health-care provider the difference between:

1. The billed amount; and
2. The maximum allowable charge for which we will provide benefits.

The amount of the difference cannot apply to satisfy any out-of-pocket expense limit.

Refer to the organ transplant surgery section of the Certificate for the definition of maximum allowable charge that applies to those services.

***Medical Necessity or Medically Necessary*** means a medical service that satisfies all of the following requirements as determined by us:

1. Must be consistent with the diagnosis and treatment of an injury or sickness;
2. Must be consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical, research, or health-care coverage organizations or governmental agencies that are accepted by the Certificate;
3. Must be known to be safe, effective, and appropriate by most doctors when the medical service is provided;
4. Cannot be provided primarily for the comfort or convenience of you or your insured dependent, a family member, or a health-care provider;
5. Is demonstrated through prevailing peer-reviewed medical literature to be either:
  - a. Safe and effective for treating or diagnosing the injury or sickness for which its use is proposed; or
  - b. Safe with promising efficacy
    - i. For treating a life-threatening injury or sickness;
    - ii. In a clinically controlled research setting; and
    - iii. Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health;

(For the purpose of this definition, the term “life-threatening” is used to describe injuries or sicknesses that are more likely than not to cause death within one year of the date of the request for treatment.)

6. Is rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the medical service. This means there is no similar or alternative medical service available at a lower cost.

The fact that a doctor has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness, or mental health condition does not mean that it is medically necessary or a covered expense as defined in the Certificate. The definition of medically necessary used in the Certificate relates only to coverage and differs from the way in which a doctor engaged in the practice of medicine may define medically necessary.

***Pre-existing Condition*** means a condition, regardless of the cause that:

1. Was present before your or your dependent’s effective date of coverage and for which medical advice, diagnosis, care, or treatment was recommended or received during the 12 months before such effective date; or
2. Produced symptoms prior to your or your dependent’s effective date of coverage. These symptoms must be distinct and significant enough to establish onset or manifestation as follows:
  - a. The symptoms would allow one learned in medicine to make a diagnosis of the disorder; or

- b. The symptoms would cause an ordinarily prudent person to seek medical diagnosis or treatment.

Benefits are limited for any pre-existing condition that existed during the above-mentioned 12 months.

We will not consider genetic information as a pre-existing condition.

We will not apply the pre-existing condition limitation to newborn children or to adopted children who are enrolled on a timely basis and who are not yet age 18.

### **Criteria Used To Determine Benefits**

We use nationally accepted criteria and internal guidelines along with provisions of the Certificate to determine eligibility of benefits.

### **Enrollee Costs**

The Certificate outlines the terms and provisions that apply to covered services on the plan and any limitations and exclusions. All eligible services are payable subject to different deductible, coinsurance and copayment amounts based on the plan design selected. The insured person may be subject to additional charges (other than copayments and coinsurance) if the billed amount is deemed to be above the maximum allowable charge we would consider eligible for payment for non-network benefits.

### **Coverage Limitations for Experimental Treatments, Procedures, Drugs, or Devices**

We evaluate new developments in medical technology through a formal review committee. Items for review include diagnostic or therapeutic procedures, medical devices, drugs, and other emerging technologies.

Peer-reviewed literature is researched for scientific evidence including information from federal regulatory agencies and nationally recognized technology researchers and vendors, including Milliman Care Guidelines and Winifred Hayes, Inc.

The recommendations made by the committee are incorporated into medical policy and made available through an internal corporate database.

### **Internal and External Grievance Procedures**

You or your representative may submit, orally or in writing, a grievance regarding any issue of dissatisfaction. The grievance should include any supporting information and should be sent to:

American Medical Security  
Appeals Review  
P.O. Box 13597  
Green Bay, WI 54307-3597  
(800) 232-5432, select 1 at the prompt and then enter Ext. 72748

The decision on the grievance will be made within 20 working days after receipt of all information reasonably necessary to complete the review. If a decision cannot be made during that time due to circumstances beyond our control, a written notice of delay will be sent before the 20<sup>th</sup> day. A decision on the grievance will be made within 10 additional working days.

Written notification of any grievance decision will be sent within five working days after the decision is made.

If you are not satisfied with the grievance decision, an appeal may be filed by you or a person on your behalf.

If the appeal of the grievance decision is filed because benefits for a proposed or rendered service were denied as not appropriate or medically necessary or as experimental or investigational, you or a person on your behalf has the right to appear, in person or by telephone, before an appeals panel of qualified individuals to present your case.

If the appeal of the grievance decision is filed because benefits for a proposed or rendered service were denied as not appropriate or medically necessary, a decision on the appeal will be made within 45 calendar days after receipt of all information reasonably necessary to complete the review.

Written notification of the appeal decision will be sent within five working days after the decision is made.

If you disagree with the appeal decision for cases involving a determination that a proposed or rendered service is not appropriate, not medically necessary, or is experimental or investigational, an independent external review is available. The written request must be filed within 45 days after the receipt of our appeal decision. The independent review organization (IRO) is to make a determination within 15 business days after the request is filed. Written notification of the determination is to be sent within 72 hours after making the determination.

### **Expedited Review Procedures**

If a determination is made that benefits for a proposed or provided service are not appropriate, not medically necessary, experimental or investigational as defined by the insurance plan, and you or your provider feels that a situation exists which may jeopardize your life, health, or ability to regain maximum function, an expedited grievance, an expedited appeal of a grievance or an expedited request for an external review may be requested. The request may be made by telephone or by facsimile.

A decision and notification (verbal and written) for a grievance or an appeal of a grievance will be made within 48 hours after all necessary information to complete the review is received.

A decision for an external review will be made by the IRO within three business days of receipt of all necessary information to complete the review. Written confirmation will be sent within 24 hours.