



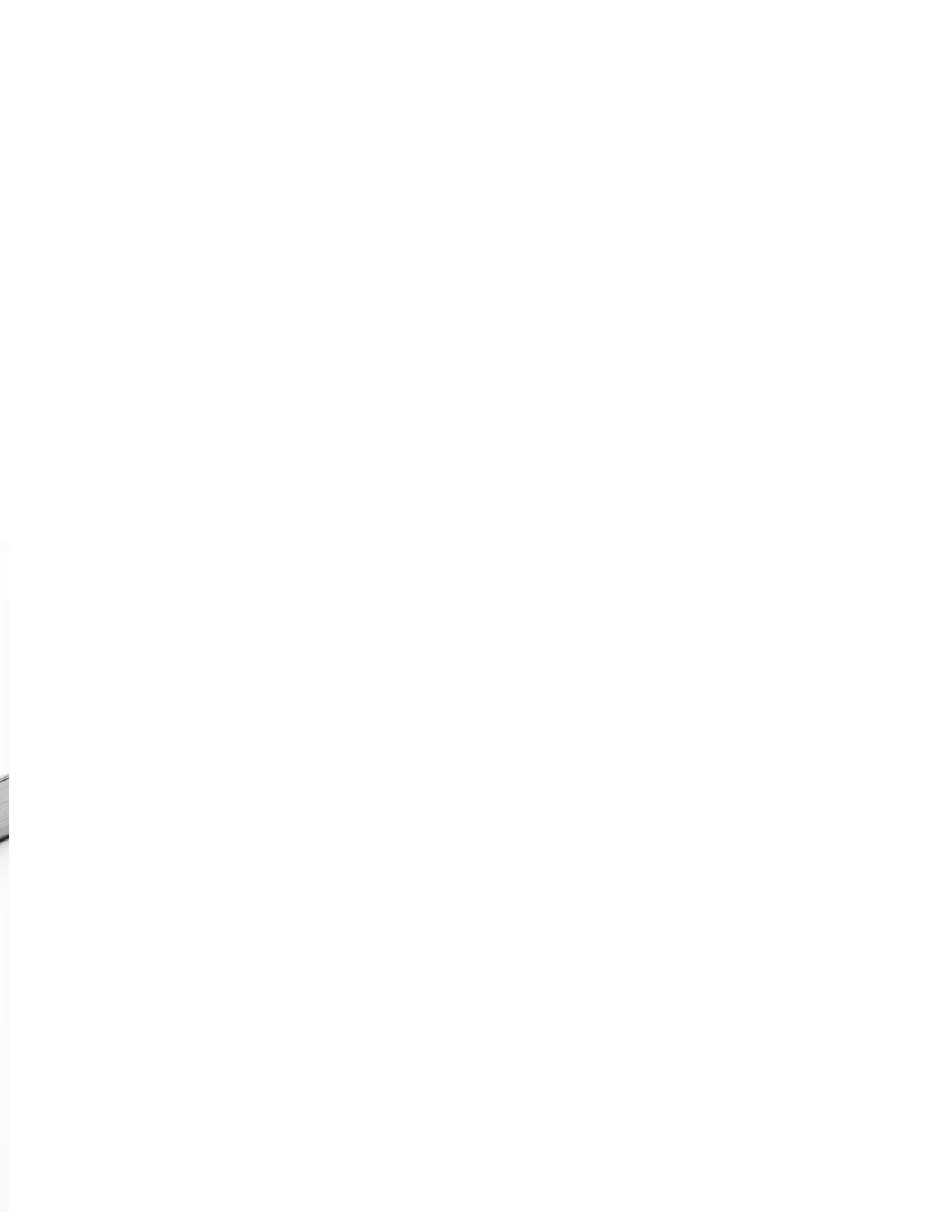
Application *Packet*

Kansas

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?*





Kansas Individual Application for Health Insurance



P.O. Box 19032, Green Bay, WI 54307-9032
(920) 661-1111 • (800) 232-5432

- 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? 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? _____

Yes No Do you intend to replace, continue, or terminate an existing life policy? If yes, please complete the Notice Regarding Replacement of Life Insurance.

COVERAGE INFORMATION

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 _____

When selecting a qualified high deductible health plan, I understand that I am required to establish a federal health savings account on the effective date of the policy. Initial Here: _____

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 guaranteed issue plan is the Kansas Health Insurance Association (high risk pool) plan.

OPTIONAL BENEFITS

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: _____

Yes No Do you want adopted child delivery coverage?

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

- B. Yes No In the past five years, have you or any eligible dependent ever been declined, postponed, ridered, 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, received therapy, taken medication, or consulted a health care provider for any reason? 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 to have a test or treatment, been advised to obtain equipment or service, been advised of a condition that may require attention or treatment, or are you awaiting the results of any medical tests or investigation? 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 (individual, employer group, short term, COBRA, Medicare, other) | 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 Individual Application for Health 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 either the date we receive the written notice or the date specified in the notice, whichever is later. 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 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 policy. 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.

State law may require a group health plan to follow rules for use of medical history, rating, renewability, and replacement of prior coverage when the plan is issued to a self-employed individual, a sole proprietor, an independent contractor, a partner, or a sole employee of a Subchapter S or Chapter C corporation. I have been made aware of regulations that may apply in my state. The producer, if applicable, has advised me about the law and I hereby certify that I do not qualify for such group health plan.

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 policy 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 the policy for medical coverage will not pay medical benefits for the first 24 months after the effective date for a disease or condition (whether mental or physical), regardless of the condition, for which medical advice, diagnosis, care or treatment was recommended or received in the 24 months prior to the effective date, 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 also understand that this application may involve the replacement of the applicant's existing life insurance. Yes No
If replacing, please complete the Notice to Applicant Regarding Replacement of Life Insurance.

- 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 6 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 _____

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

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 15th 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



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 or 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 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.

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.

KANSAS DISCLOSURE NOTICE For Medical Insurance Plans

Kansas Statute 40-4606 requires that the following information be made available to both current and prospective insureds upon request.

- A complete description of the health-care services, items and other benefits to which you are entitled in the particular health benefit plan that is currently covering you or being offered to you.
- A description of limitations, exceptions, or exclusions to coverage in the health benefit plan, including prior authorization policies, restricted drugs formularies, or any other provisions that restrict access to covered services or items by the insured.
- A listing of the health benefits plan's participating providers, providers' business addresses and telephone numbers, availability of these providers, and any limitations on your choice of provider. Not all plans have network providers.
- A description of the grievance and appeal procedure available under your health benefit plan.
- A description of your rights regarding termination, disenrollment, nonrenewal, or cancellation of coverage.
- Notification in advance of any changes in the health benefit plan that either reduce the coverage or benefits, or increases the cost. Notification will be made directly to employers for employer-sponsored plans.

Current insureds can find this information in their Certificate of Group Insurance/Individual Major Medical Expense Policy. Prospective insureds may request additional information by calling (800) 232-5432, press 1 at the prompt and then enter Ext. 15401. Participating provider information is listed on the American Medical Security Web site, www.eAMS.com.



P.O. Box 19032, Green Bay, WI 54307-9032
(920) 661-1111 • (800) 232-5432

American Medical Security Life Insurance Company, 3100 AMS Blvd., P.O. Box 19032, Green Bay, WI 54307-9032, (800) 232-5432, underwrites fully insured products and provides administrative services for the following insurance companies: United HealthCare Insurance Company and other insurers.

**IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES**

This document must be signed by the applicant and the producer, and a copy left with the applicant.

You are contemplating the purchase of life insurance. In some cases this purchase may involve discontinuing or changing your existing life insurance. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when new life insurance is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of new life insurance involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the new life insurance values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new life insurance. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your existing policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ___YES ___NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new life insurance? ___YES ___NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number, if available) and whether each policy or contract will be replaced or used as a source of financing:

| Insurer Name | Contract or Policy Number | Insured or Annuitant | Replacing (R) or Financing (F) |
|-------------------------|--------------------------------------|---------------------------------|---|
| | | | |
| | | | |
| | | | |

Make sure you know the facts. Contact your existing company or its agent for information about the existing policy or contract. If you request, an in-force illustration, policy summary, or available disclosure documentation must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____.

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant's Signature and Printed Name

Date

Producer's Signature and Printed Name

Date

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed life insurance policy. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare the existing policy or contract with the proposed life insurance. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

Premiums: Are they affordable?
Could they change?
You're older—are premiums higher for the proposed new life insurance policy?
How long will you have to pay premiums on the new life insurance policy? On the old policy?

Policy Values: This new policy has no cash value nor does it pay dividends.
Acquisition costs for the old policy may have been paid. You may incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new life insurance policy?
Does the new life insurance policy provide more insurance coverage?

Insurability: If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new life insurance policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.

If You Are Keeping the Old Policy as well as the New Life Insurance Policy:

How are premiums for both being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

If You Are Surrendering an Annuity or Interest-Sensitive Life Product:

Will you pay surrender charges on your old contract?
Have you compared the contract charges or other policy expenses?

Other Issues To Consider for All Transactions:

What are the tax consequences of buying the new life insurance policy?
Is this a tax-free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the existing policy?
How do the quality and financial stability of the new company compare with your existing company?

If you replace an existing life insurance policy, you'll have the right to return the new life insurance policy that we issue within 20 days from the date we deliver the life insurance policy to you. If you return the life insurance policy to us in that timeframe, we'll provide you with an unconditional full refund of all life insurance premiums.

