

Application *Packet*

Oklahoma

Have you:

- ✓ *Signed all forms necessary?*
- ✓ *Answered all applicable questions?*
- ✓ *Selected a method of payment?*



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.

Oklahoma 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 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 _____

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

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 as defined in the Prior Coverage section on page 3 of this application 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 Oklahoma 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: _____

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.)

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

- B. Yes No 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 <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. Please contact your producer, if applicable, 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. Except as otherwise indicated under the Coverage Information section of this Application, AMS will waive the pre-existing limitation 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.

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 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 will not pay benefits during the first 12 months after the effective date for a pre-existing disease or physical condition 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 (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 24 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.

Payment Authorization Form

A. APPLICANT INFORMATION

Last Name _____ First Name _____ SS No. _____

B. INITIAL METHOD OF PAYMENT

Automatic Bank Draft (Complete Bank Draft Authorization below.) Credit Card (Complete Credit Card Authorization below.) Check Enclosed

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 _____ Expiration Date _____
(16 digits required) (MM/YYYY)

As a convenience, I request and authorize American Medical Security Life Insurance Company (AMS) to charge the credit card account, identified above, for the payment of the health plan premium and any fees for the payment option(s) designated. In submitting this payment authorization with the application, I understand that the initial premium for the health plan may be adjusted based on the applicant's 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 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

Semiannual

Annual

Monthly Direct Bill (available in CA only)

List Bill*

* Additional forms are required. Not available in some states.

BANK DRAFT AUTHORIZATION

Type of Account: Checking Savings

Account Holder's Name _____ Financial Institution _____
(As it appears on financial institution records.)

Routing/Transit Number (9 digits required) _____ Account Number (9 digits required) _____

I hereby authorize AMS to initiate debit entries to the 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. AMS is not responsible for charges I may incur from my bank due to late notification of the termination or change. 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.

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.

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

Signature of Primary Applicant/Parent or Legal Guardian X _____ Date _____

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

(800) 232-5432 • www.eAMS.com

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Medical Security[®]

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Insurance products are underwritten by American Medical Security Life Insurance Company.