

Applicant's Initials: _____
 Last 4 Digits of SS#: _____



PREFERRED PROVIDER POLICY WITH MAJOR MEDICAL BENEFITS – APPLICATION FORM

Please print clearly using a black pen. The application must be completed in its entirety by the person who is listed as the primary applicant. After carefully reading each section and answering the questions, be sure to sign and date the application. Applicant #1 is the primary applicant. List only persons who are applying for coverage except for child(ren)-only coverage under which the parent, though not applying, must be listed as the primary applicant. Incomplete applications will be returned. **PLEASE DO NOT CANCEL ANY OTHER EXISTING HEALTH INSURANCE UNTIL YOU HAVE RECEIVED WRITTEN CONFIRMATION OF APPROVAL FROM IMERICA.**

A. APPLICATION TYPE

Your insurance agent can help you set up an online application.

<input type="checkbox"/> New Application	If reapplying, print existing Imerica policy number below: _____
<input type="checkbox"/> Reapplying	
<input type="checkbox"/> Reapplying w/ medical records	
<input type="checkbox"/> Add Dependent	
<input type="checkbox"/> Add Spouse	

B. PERSONAL AND GENERAL INFORMATION

Name of Family Members Print First Name, Middle Initial and Last Name	Birth Date MM/DD/YYYY	Age	Marital Status	Sex	Social Security Number	Height & Weight	Tobacco Use Last 12 Months
1 Primary Applicant First: _____ MI: _____ Last: _____ Occupation: _____	____ / ____ Year: _____		<input type="checkbox"/> S <input type="checkbox"/> M	<input type="checkbox"/> M <input type="checkbox"/> F	_____ - ____ - _____	ft: ____ in: ____ lbs: ____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Job Title: _____ Duties: _____ Industry: _____ Check if Applicable: <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partner <input type="checkbox"/> Owner							
Primary Applicant's Beneficiary Name: _____ Relationship: _____ Are any family member(s), including spouse, not applying for coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," why? _____ Name(s): _____							
2 Spouse First: _____ MI: _____ Last: _____ Occupation: _____	____ / ____ Year: _____		<input type="checkbox"/> S <input type="checkbox"/> M	<input type="checkbox"/> M <input type="checkbox"/> F	_____ - ____ - _____	ft: ____ in: ____ lbs: ____	<input type="checkbox"/> Yes <input type="checkbox"/> No
3 Dependent 1 First: _____ MI: _____ Last: _____ Full Time Student: <input type="checkbox"/> Yes <input type="checkbox"/> No College: _____	____ / ____ Year: _____		<input type="checkbox"/> S <input type="checkbox"/> M	<input type="checkbox"/> M <input type="checkbox"/> F	_____ - ____ - _____	ft: ____ in: ____ lbs: ____	<input type="checkbox"/> Yes <input type="checkbox"/> No
4 Dependent 2 First: _____ MI: _____ Last: _____ Full Time Student: <input type="checkbox"/> Yes <input type="checkbox"/> No College: _____	____ / ____ Year: _____		<input type="checkbox"/> S <input type="checkbox"/> M	<input type="checkbox"/> M <input type="checkbox"/> F	_____ - ____ - _____	ft: ____ in: ____ lbs: ____	<input type="checkbox"/> Yes <input type="checkbox"/> No
5 Dependent 3 First: _____ MI: _____ Last: _____ Full Time Student: <input type="checkbox"/> Yes <input type="checkbox"/> No College: _____	____ / ____ Year: _____		<input type="checkbox"/> S <input type="checkbox"/> M	<input type="checkbox"/> M <input type="checkbox"/> F	_____ - ____ - _____	ft: ____ in: ____ lbs: ____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Resident Address - Actual address, we cannot accept a P.O. Box.

Address: _____ Suite / Apt: _____
 City: _____ State: _____ Zip: _____

Mailing Address: _____ Suite / Apt: _____
 City: _____ State: _____ Zip: _____

Does any applicant live at a different address? Yes No If "Yes," who? _____
 If "Yes," where?
 Address: _____ Suite / Apt: _____
 City: _____ State: _____ Zip: _____

Applicant's Initials: _____
 Last 4 Digits of SS#: _____



Contact Information - This section must be completed	E-mail Address: _____ @ _____
A telephone interview may be conducted in connection with this application.	Fax Number: (_____) _____ - _____
Contact Name: _____	Other: _____
Phone Number: Work (_____) _____ - _____	Primary Applicant's Place of Birth
Home (_____) _____ - _____	City: _____ State: _____
Best place to call: _____	Country: _____
Best time to call: _____ AM _____ PM	Spouse's Place of Birth
	City: _____ State: _____
	Country: _____

C. PLAN SELECTION

HIGH DEDUCTIBLE HEALTH PLANS (HSA Qualified)		Coinsurance	Deductible
Select your Plan			
1	<input type="checkbox"/> HSA Single Series	<input type="checkbox"/> 100%	<input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,850 <input type="checkbox"/> \$5,500
	<input type="checkbox"/> HSA Family Series	<input type="checkbox"/> 100%	<input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,650 <input type="checkbox"/> \$7,500
2	<input type="checkbox"/> HSA Single Series	<input type="checkbox"/> 80% / 20%	<input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,850
	<input type="checkbox"/> HSA Family Series	<input type="checkbox"/> 80% / 20%	<input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,650 <input type="checkbox"/> \$7,500
3	<input type="checkbox"/> HSA Series	<input type="checkbox"/> 100%	<input type="checkbox"/> \$5,000 (\$10,000 combined family)

MAJOR MEDICAL INSURANCE (Non-HSA Qualified)	Coinsurance	Deductible	Maternity Options
Select your Plan			
<input type="checkbox"/> PPO Series	<input type="checkbox"/> 80% to \$10,000	<input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000	<input type="checkbox"/> Yes <input type="checkbox"/> No

Lifetime Maximum Benefit: \$2,000,000 \$5,000,000 \$8,000,000

Requested Effective Date: 1st 15th Month: _____

PPO Network: _____

OPTIONAL BENEFITS – Select optional benefits for all plans above.

Bone Marrow Transplant Rider	Human Heart Transplant Rider	Mental Disorder Benefit Rider	Supplemental Accident	Morbid Obesity Benefit Rider	Life Insurance Primary Insured \$10,000	Life Insurance Spouse/Dependent(s) * \$10,000/\$5,000
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

*Spouse/Dependent life insurance is only available if primary life insurance is elected. The Spouse/Dependent(s) beneficiary is the primary insured.

C. (a) 24-HOUR OCCUPATIONAL HEALTH INSURANCE COVERAGE

If you are not covered by workers compensation, you may be eligible for 24-hour occupational health insurance coverage. Do you wish to elect this benefit? (Verification may be required. Subject to underwriting approval.) Primary Applicant: Yes No Spouse: Yes No

D. CURRENT / PRIOR CARRIER INFORMATION

Person(s) Covered	Prior Carrier	Policy / Certificate Number	Employer Provided	Effective Date	Termination Date	If Active, Termination Date
1			<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___	___/___/___	___/___/___
2			<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___	___/___/___	___/___/___

D.(a)

Will the coverage being applied for replace any existing hospital, medical or major medical insurance when this coverage is approved by Imerica and accepted by the applicant? Yes No

E. ELIGIBILITY

1. Are all applicants citizens of the United States? Yes No
If "No," Answer A-C
 A. Do all applicants have a permanent visa or green card status? Yes No
 B. Do all applicants have an established U.S.A. physician? Yes No
 C. Have all applicants resided in the U.S.A. continuously for the prior 12 months? Yes No
Please attach a copy of valid visa or green card - both sides. If any of A-C is answered "No," coverage is not available.

2. Has any applicant lived outside the U.S.A. for a period of one continuous month or more in the last two years or plan to live outside the U.S.A. for a period of one continuous month or more in the next two years?
 Yes No
 If "Yes," state name, date(s), reason(s) and where: _____

3. Are any applicants currently disabled or receiving any payments due to a disability? Yes No
 If "Yes," which applicant? _____
Coverage is not available for applicants receiving disability benefits.

4. In the past 10 years, has anyone to be covered had any form of life or health insurance denied, rescinded, waived, coverage limited, or increased initial premium (rate-up)? Yes No
 If "Yes," state name and reason for modification or denial: _____
 If "Yes," year: _____

5. Is any person to be covered a college student? Yes No
 If "Yes," state name, name of college and anticipated date of graduation:
 Name: _____
 College: _____
 Graduation Date: ___/___/___

6. Has any person to be covered ever been convicted of a felony or is anyone currently on probation? Yes No
 If "Yes," state class of felony and date of conviction.
 Name: _____
 Felony: _____
 Date: ___/___/___
Persons on parole are not eligible for coverage.

7. Has any person to be covered had 2 or more moving driving violations in the past 2 years or had a DUI or DWI in the past 5 years? Yes No
 If "Yes," name: _____
 Driver License #: _____ State: _____

8. Is the applicant and/or spouse covered by workers' compensation?
 Applicant: Yes No
 Spouse: Yes No
 If "No," is applicant and/or spouse eligible to opt out of workers' compensation?
 Applicant: Yes No
 Spouse: Yes No

9. In the past 2 years, has any person to be covered piloted a private aircraft or participated in sky diving, scuba diving; motor vehicle, boat or snowmobile racing; mountain or rock climbing; hang gliding; rodeos or any other hazardous activities? Yes No

10. Has any applicant ever had prior medical insurance with Imerica?
 Yes No
 If "Yes," name? _____ When? _____

F. MEDICAL ELIGIBILITY - Applies to ALL applicants - For all "Yes," answers furnish additional detail in Section G, next page

- 1. Are you, your spouse or any dependent now pregnant? Yes No
- 2. Is any person now pregnant by any person to be insured? Yes No
- 3. Is any person to be covered in the process of adopting a child? Yes No
- 4. Within the past 10 years, has any person to be covered:
 - a) Been a member of any alcohol or drug abuse support group, or had treatment or counseling for alcohol abuse, alcoholism or drug abuse or has such treatment or counseling been recommended by a physician? Yes No
 - b) Used any controlled drug not prescribed by a doctor? Yes No
 - c) Been convicted of driving while under the influence of alcohol or any drug? Yes No
- 5. Within the past 10 years, has any person to be covered had any signs or symptoms of, been told he or she had, sought or been advised about, been told to have treatment for, had follow-up visits for, or received medication or treatment, been hospitalized for:
 - a) High or low blood pressure; heart attack; heart murmur, mitral valve prolapse or valve disorder; heart infection, endocarditis or pericarditis; chest pain or angina; irregular heart beat or palpitations; stroke, CVA or aneurysm; vein or artery disease or disorder; blood or bleeding disorder; blood clot or any other disease or disorder of the heart or circulatory system? Yes No
 - b) Migraines or headaches; dizziness; fainting; weakness; epilepsy; seizures; numbness or tingling; paralysis; sleep disorder, brain disorder or disease; Parkinson's disease; Alzheimer's disease, cognitive disorder or other disease or disorder of the brain or nervous system? Yes No
 - c) Elevated cholesterol or triglycerides, low HDL or high LDL; obesity; diabetes or sugar intolerance; disease or disorder of the thyroid, pituitary or adrenal glands? Yes No
 - d) Any disease or disorder of the kidney(s); bladder; prostate; kidney or bladder stones; cystitis; infection, sexually transmitted disease or other disorder of the genito-urinary system? Yes No
 - e) Breast cysts or other breast disease or disorder; abnormal Pap smears; infertility; abnormal uterine bleeding; excessive menstruation; endometriosis; or complications of pregnancy? Yes No
 - f) Low sperm count, impotence, sexual dysfunction, penile or scrotal implant, undescended testicles? Yes No
 - g) Hernia; esophageal reflux (GERD); gallbladder disease or disorder; stomach, intestine or rectal disorder such as colitis, Crohn's disease, ulcer, hemorrhoids, colon polyps or any other digestive disorder? Yes No
 - h) Liver or pancreatic disorder included but not limited to, hepatitis, pancreatitis, cirrhosis, fatty liver or abnormal liver enzymes; esophageal varices; or jaundice? Yes No
 - i) Asthma; reactive airway disease; allergies; hay fever; shortness of breath; bronchitis; sleep apnea; obstructive pulmonary disease; emphysema; tuberculosis; chronic cough, spitting up blood, or any other disease or disorder of the respiratory system? Yes No
 - j) Anxiety, depression, emotional or behavioral disorder; eating disorder, attention deficit disorder; chronic fatigue syndrome; or any disease or disorder of the nervous system? Yes No
 - k) Arthritis; gout; fibromyalgia; rheumatism; osteoporosis, spinal disc disorder; back sprain; hip or knee replacement, pin or hardware, fracture, amputation, post-polio or any other disorder of the bones, joints or muscles? Yes No
 - l) Blindness; cataracts; hearing loss; ear infections, otitis media, excessive snoring, problems with tonsils or adenoids, deviated nasal septum, or other eye, ear, nose or throat disorders? Yes No
 - m) Systemic lupus or other connective tissue disease or disorder; cancer; tumor or cyst; acne; anemia; hemophilia; or any other disease or disorder of the skin, blood, lymph or immune systems? Yes No
- 6. Has any person to be covered ever had or been told he or she had, symptoms of, sought or been advised to have treatment for, had follow-up visits for or received medication for: cancer; heart attack or disease; stroke; aneurysm; multiple sclerosis; surgical implant such as but not limited to pins, screws, plates, breast implants, bone or tissue implant, pacemakers, shunts or valve replacements? Yes No
- 7. Within the past 10 years:
 - a) Has any person to be covered been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) by a member of the medical profession? Yes No
 - b) Has any person to be covered been diagnosed as having or been treated for any immune deficiency disorder by a member of the medical profession? Yes No
- 8. Within the past 5 years, has any person to be covered:
 - a) Consulted or been examined or treated by any physician, chiropractor, psychologist or other healthcare practitioner? Yes No
 - i) Were any exams, consultations, tests or treatments prompted by symptoms or complaints? Yes No
 - ii) Were you advised of any abnormal findings? Yes No
 - b) Been to a clinic, hospital, outpatient center, or other medical facility for treatment, surgery, confinement or observation? Yes No
 - c) Had an ongoing or intermittent fever of more than three weeks' duration; weight loss of more than 15 pounds in two months; recurrent fatigue; diarrhea of more than one month's duration; persistent skin rash; infections or sores of the mouth? Yes No
 - d) Had or been advised to have treatment, surgical procedure or additional testing that has not been completed? Yes No
 - e) Had an electrocardiogram, chest x-ray, MRI, CT scan or any other diagnostic testing of any kind or been hospital confined? Yes No
- 9. Has anyone to be covered used tobacco products within the past 10 years? Yes No
 - a) If "Yes," complete the following for all current and past users:
Person's Name: _____
Date last used: ____ / ____ / ____
Check products used:
 Cigarettes Cigars Chewing Tobacco Nicotine Replacements
Person's Name: _____
Date last used: ____ / ____ / ____
Check products used:
 Cigarettes Cigars Chewing Tobacco Nicotine Replacements

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G. ADDITIONAL DETAILS TO MEDICAL QUESTIONS - Include information on every "Yes" answer listed in Section F and all physician, hospital or health facility within the past 12 months. Attach extra pages if you need more space.

Question #	Person's Name	Condition	Details (date of onset, treatment and date released from treatment)
	Physician's Name: _____ Phone: (_____) _____ - _____		
	Address: _____ Suite / Apt: _____ City: _____ State: _____ Zip: _____		
	Physician's Name: _____ Phone: (_____) _____ - _____		
	Address: _____ Suite / Apt: _____ City: _____ State: _____ Zip: _____		
	Physician's Name: _____ Phone: (_____) _____ - _____		
	Address: _____ Suite / Apt: _____ City: _____ State: _____ Zip: _____		
	Physician's Name: _____ Phone: (_____) _____ - _____		
	Address: _____ Suite / Apt: _____ City: _____ State: _____ Zip: _____		

List all medications including prescription, over-the-counter medications and dietary supplements taken in the last 12 months by any applicant. Attach extra pages if you need more space.

Person's Name	Medication	Dosage / Frequency	Illness / Condition	Date Began	Date Discontinued
				___/___/___	___/___/___
Physician's Name: _____ Phone: (_____) _____ - _____					
Address: _____ Suite / Apt: _____ City: _____ State: _____ Zip: _____					
				___/___/___	___/___/___
Physician's Name: _____ Phone: (_____) _____ - _____					
Address: _____ Suite / Apt: _____ City: _____ State: _____ Zip: _____					
				___/___/___	___/___/___
Physician's Name: _____ Phone: (_____) _____ - _____					
Address: _____ Suite / Apt: _____ City: _____ State: _____ Zip: _____					
				___/___/___	___/___/___
Physician's Name: _____ Phone: (_____) _____ - _____					
Address: _____ Suite / Apt: _____ City: _____ State: _____ Zip: _____					
				___/___/___	___/___/___
Physician's Name: _____ Phone: (_____) _____ - _____					
Address: _____ Suite / Apt: _____ City: _____ State: _____ Zip: _____					

H. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Federal law provides for waiving of pre-existing conditions limitation period for qualified persons applying under HIPAA. HIPAA qualified individuals must meet all of the following criteria:

1. Must have 18 months of continuous credible coverage and this coverage has not been lapsed for 63 days or more
2. Most recent coverage must be a group, governmental or church plan
3. Must not be eligible for group coverage, Medicare or Medicaid
4. Cannot have other health insurance coverage
5. Must have elected and exhausted any COBRA or state continuation coverage
6. Most recent coverage must not have terminated due to premium lapse or fraud

Do you or any dependent desire to apply under HIPAA? Yes No **If "Yes," who?** _____

Please note that additional premium may be required for all HIPAA applicants. All "HIPAA Eligibility Questions" on the HIPAA Eligibility Questionnaire (available through your agent) must be completed. Your responses to health and avocation questions will not be used to determine HIPAA eligibility.

I. AGREEMENT

I am aware of the pre-existing condition limitation provisions. I understand that the coverage for each applicant, if approved, will be subject to a pre-existing condition limitation unless disclosed in the medical history section of this application and not specifically excluded by name from coverage under the certificate.

I understand that this insurance is not designed nor marketed as employer-provided insurance. I certify that (1) my employer does not pay for a portion of the premium or benefits; (2) neither my employer nor I as a covered individual under this plan treat the health benefit plan as part of a plan or program for purposes of Section 106 or 162, Internal Revenue Code of 1986 (26 U.S.C. Section 106 or 162); and (3) the health benefit plan is not an employee welfare benefit plan under 29 C.F.R. Section 2510.3-1(j). I understand that the responses contained herein will be relied upon by Imerica Life and Health Insurance Company in the issuance of a certificate of insurance. I declare all statements contained herein are true and correct and that no material information has been withheld or omitted. I understand and agree that the Insurer is not bound by any statement made or to any agent unless written herein. I understand that the agent has no authority to advise me to omit or inaccurately report any information requested herein. I understand that material omissions or misstatements may be grounds for rescission of, reformation of, or the increasing of premiums payable for coverage under the policy. A change in the health of the proposed insured(s) after the completion of the enrollment application and before the date Imerica approves the application may affect my eligibility for insurance with the company.

I agree that no insurance will be effective until the date specified by the insurer in the certificate of coverage. The actual effective date may not be the requested effective date.

Any person who, knowingly and with intent to injure or deceive any insurer, files a claim or an application containing any false; Incomplete or misleading information, is guilty of a felony of the third degree, as determined by a court of competent jurisdiction.

Pre-notice of disclosure of information: Information regarding your insurability will be treated as confidential. Imerica Life and Health Insurance Company, or its reinsurers may, however, make a brief report to the Medical Information Bureau, a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures from the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, and telephone number (617) 426-3660. Imerica Life and Health Insurance Company, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted

X _____ Date: _____
Signature of Applicant

X _____ Date: _____
Electronic Signature

X _____ Date: _____
Signature of Spouse (if applying)

X _____ Date: _____
Electronic Signature

X _____ Date: _____
Signature of Dependents 18 or Over (if applying)

X _____ Date: _____
Electronic Signature

X _____ Date: _____
Signature of Dependents 18 or Over (if applying)

X _____ Date: _____
Electronic Signature

J. AUTHORIZATION TO RELEASE INFORMATION

This authorization complies with the HIPAA Privacy Rule.

**I authorize the disclosure of information regarding, or related to, the following individuals for whom an application for insurance has been submitted:
 (To be completed for each person applying for coverage.)**

Name(s):

Last	First	Middle	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

By signing below, I authorize any and all healthcare providers including without limitation licensed physicians, medical practitioners, hospitals, clinics, or other medical or medically related facilities, pharmacy benefit managers, pharmacies or pharmacy-related facilities; and any and all health plans, insurance companies, healthcare clearinghouses, insurance support groups such as the Medical Information Bureau (MIB), business associates of health plans or insurance companies and those persons or entities providing services to such business associates or any other organization, institution or person including but not limited to public health authorities, employers, schools or universities that have created or received any information about me or my family members named in this authorization, to disclose the information described below.

I authorize the disclosure of any and all information that relates to the past, present, or future physical or mental health or condition of an individual listed above; the provision of healthcare to an individual listed above; or the past, present, or future payment for the provision of healthcare to a person listed above. This authorization permits the disclosure of all medical records including without limitation those containing information relating to consultation, advice, care, prescription drug information, diagnosis, treatment and prognosis with respect to any physical or mental condition, of an individual listed above and non-medical information of an individual listed above. This information may also be disclosed to any medical records company engaged by Imerica.

I specifically authorize the disclosure of information related to (1) communicable diseases, including HIV, AIDS or AIDS related complex (to the extent permitted by state and federal law); (2) drug and alcohol abuse and treatment; (3) mental illness and treatment; and (4) genetic conditions including genetic testing (to the extent permitted by state and federal law). Notwithstanding the above, this authorization does not authorize the release of psychotherapy notes.

I authorize Imerica and its business associates, including those persons or entities providing services to its business associates, to receive the disclosure of information authorized herein and use the information disclosed pursuant to this authorization.

I understand that the information obtained by use of the authorization will be used by Imerica and its business associates, including those persons or entities providing services to its business associates, to determine eligibility for insurance or to determine eligibility for benefits under the policy.

I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

I understand that eligibility for the health plan is conditioned on my execution of this authorization for the use or disclosure of the information described above for the purpose of making eligibility, underwriting and risk rating determinations. Except as otherwise stated herein, treatment, payment, enrollment in a health plan, or eligibility for benefits is not conditioned on an authorization for the use or disclosure of the information described above.

I know that I may request to receive a copy of this authorization. I know that I may request to be interviewed if an investigate consumer report is prepared in connection with this application. I agree that a photographic copy or facsimile of this authorization shall be as valid as the original. This authorization shall expire thirty (30) months after the date signed below. I understand this authorization may be revoked by sending written revocation to Imerica, Attn: Privacy Officer- 304 Inverness Way South, Suite 355, Englewood, CO 80112.

Signature of each individual over the age of 18 or the individual's legal representative:

X _____ <i>Signature of Applicant</i>	Date: _____
X _____ <i>Electronic Signature</i>	Date: _____
X _____ <i>Signature of Spouse (if applying)</i>	Date: _____
X _____ <i>Electronic Signature</i>	Date: _____
X _____ <i>Signature of Dependents 18 or Over</i>	Date: _____
X _____ <i>Electronic Signature</i>	Date: _____
X _____ <i>Signature of Dependents 18 or Over</i>	Date: _____
X _____ <i>Electronic Signature</i>	Date: _____

If signed by individual's legal representative, describe the legal representative's authority to sign on behalf of the individual:

Applicant's Initials: _____
Last 4 Digits of SS#: _____



K. WRITING AGENT INFORMATION AND STATEMENT

Writing Agent's Name _____ Agency Name _____
Street Address _____ City _____ State _____ Zip _____
Phone Number _____ Fax Number _____ E-mail Address _____
I certify that I have had contact with the applicant(s). I also certify that I have truly and accurately recorded all the information given to me by the applicant(s), and I certify that I know of no other medical information about those person(s) applying for coverage other than that contained on this application. I certify that the applicant(s) has either filled out the application or has personally reviewed the completed application. I have explained all benefits, exclusions and limitations of the plan, as well as out of pocket penalties if a non-PPO provider is utilized.
I personally met with the following applicant(s): In Person Via Phone Internet No Contact _____
Writing Agent's Signature X _____ ID Number _____ Date _____
Electronic Signature X _____ Date _____
MGA _____
General Agency _____

L. INITIAL PREMIUM PAYMENT INFORMATION

If initial premium payment is being made by credit card, please complete this section.

A one-time application fee of \$25.00 will be added.

Type of Card: VISA MasterCard

Cardholder's Name _____ Card Number _____ Expiration date (Month/Year) _____

Billing Address _____ City _____ State _____ Zip _____

X _____ Date: _____

Signature of Cardholder

X _____ Date: _____

Electronic Signature

If initial premium payment is being made by Electronic Funds Transfer (EFT), please complete this section.

A one-time application fee of \$25.00 will be added.

Payer's Name _____

Street Address _____ City _____ State _____ Zip _____

Financial Institution _____

Street Address _____ City _____ State _____ Zip _____

Specify type of account: Checking Savings

Account Number: _____ ABA 9 Digit Routing Number: _____

Routing number can be found to the left of your account number.

I hereby authorize Imerica, herein called COMPANY, to initiate debit entries to the account indicated above and the depository named above, herein after called DEPOSITORY, to debit the same to such account.

This authority is to remain in full force and effect until COMPANY and DEPOSITORY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

X _____ Date: _____

Signature of Payer

X _____ Date: _____

Electronic Signature

If initial premium payment is being made by check, please complete this section.

Check must be made payable to *Imerica Life and Health Insurance Company*.

Application Fee: \$ _____

Estimated 1st premium payment: \$ _____

Check #: _____ Total: \$ _____

M. FUTURE PREMIUM PAYMENT METHODS - CHOOSE AN OPTION AND A MODE.

Choose Option: Electronic funds transfer Direct Bill (Add \$10 per mode) Credit Card

Choose Mode: Monthly Quarterly Semi-Annually Annually

Applicant's Initials: _____
Last 4 Digits of SS#: _____

P. Statement of Accountability – To be completed when the applicant cannot complete the application

I, _____, personally read and completed this Individual Enrollment Application for the applicant named below because:

- Applicant does not read English Applicant does not speak English
 Applicant does not write English Other (*explain*) _____

Applicant's Primary Language: _____

I translated the contents of this form and to the best of my knowledge, obtained and listed all the requested personal and medical history disclosed by: _____

By: _____
Signature of Translator

Today's Date (*Required*)

By: _____
Electronic Signature

Today's Date (*Required*)

Imerica Life and Health Insurance Company Presents:

1STBANK Health Savings Accounts

Health insurance is changing dramatically, and Imerica and FirstBank are here to help you take advantage of new opportunities.

Many employers, families and individuals are choosing high deductible health plans due to rising costs, but many are also concerned about how to pay for medical expenses before the deductible is met.

Today, there is a new choice – Health Savings Accounts or HSAs.

An HSA allows an employer or individual to make tax-deductible contributions to a savings account, which the employee may then use to pay for medical expenses. Self-employed individuals may also have health savings accounts. In such cases, the business owner is both the employer and the employee.

SAVE ON TAXES.

HSAs are similar to IRAs in that contributions to an HSA are tax-exempt and the earnings are tax-deferred. If funds are used for qualified medical expenses, HSA assets are never taxed.

PAY MEDICAL EXPENSES.

For HSA assets to retain their tax free status, funds may be used for only certain expenses including:

- Actual medical expenses, including doctor visits, prescriptions, transportation to get medical care, and dental care
- Long-term care insurance
- Healthcare insurance coverage when unemployed, certain continuation-of-benefit healthcare coverage, and certain health insurance after age 65

HSA funds used for non-qualified expenses are subject to taxes and a 10% IRS penalty.

SAVE FOR RETIREMENT.

Any funds remaining in your HSA at the end of the year roll over to the next year and can continue building tax-deferred, year after year. At age 65, you may withdraw your HSA funds with no penalties. If you use the money for eligible medical expenses, the funds remain tax-exempt.

YOUR HSA BELONGS TO YOU.

Regardless of who makes contributions to your HSA, the account belongs to you. You cannot lose it even if you change jobs. You may even use it to pay for healthcare insurance if you become unemployed.

USE IT, OR LET YOUR HSA GROW – YOU DECIDE.

You are not required to use your HSA to pay for healthcare expenses. You may use other funds for healthcare and let the money in your HSA continue to grow.

WHO IS ELIGIBLE TO ESTABLISH AN HSA?

As an Imerica policyholder, you are an eligible individual for any month if you are:

- Covered under an HDHP on the first day of the month and
- Not also covered by any other health plan that is not an HDHP (with limited exceptions) and
- Not enrolled for benefits under Medicare and
- Not eligible to be claimed as a dependent on another person's tax return

WHAT IS CONSIDERED AN HDHP?

A high-deductible health plan (HDHP) is an insurance policy that meets certain dollar limits as shown in the table below:

2008 HDHP LIMITS*		
	Self Only	Family
2008 Annual Deductible	\$1,100 or more	\$2,200 or more
2008 Annual Deductible plus out-of-pocket expenses cannot exceed	\$5,600	\$11,200

*HDHP limits are revised each year to reflect cost-of-living increases.

Your Imerica HDHP is HSA qualified.

Applicant's Initials: _____
Last 4 Digits of SS#: _____

WHAT ARE THE ANNUAL HSA CONTRIBUTION LIMITS?

The contribution limit for individuals for 2008 is \$2,900, and the contribution limit for families is \$5,800.

Contribution limits are revised each year to reflect cost-of-living increases.

If you have attained age 55 before the close of the taxable year, you may also contribute an additional amount known as a "catch-up" contribution.

Catch-up contribution limits are as follows: \$900 in 2008 and \$1000 in 2009 and following years.

Please check with your Imerica representative for HDHP details.

YOUR FIRSTBANK HEALTH SAVINGS ACCOUNT OFFERS MANY USER-FRIENDLY BENEFITS:

- Competitive interest rates on Money Market Checking Accounts. View our rates online at efirstbank.com
- Unlimited check writing privileges
- ATM access with no-fee FirstTeller Visa HSA card
- Monthly account statements
- Free Internet access, eStatements, optional bill pay service and financial downloads
- 24-hour Telephone Banking service

SETTING UP A HEALTH SAVINGS ACCOUNT.

To open your HSA, please complete the FirstBank HSA application and return it with your opening deposit check (if applicable) to your Imerica broker. You will be notified within 10 days of your account activation.

SCHEDULE OF FEES.

- No set-up fee
- No monthly bank service charges
- Up to 2 FirstTeller Visa HSA Cards with no annual fee
- \$25 annual administrative fee per account - waived the first year



**For more information, please call (800) 964-3444.
For specific tax information, please consult your tax advisor.**

Open your new Health Savings Account today!

efirstbank.com

Member FDIC • Each Depositor Insured to at Least \$100,000
©2007 FirstBank Holding Company



FIRSTBANK HEALTH SAVINGS ACCOUNT APPLICATION

Please complete the following information to establish a FirstBank Health Savings Account:

Note: To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. What this means for you: When you open an account, we will ask your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents. Thank you for your cooperation. If you have any questions regarding the application, please call us at (800) 964-3444.

1. HSA OWNER INFORMATION

Contact Information - This section must be completed	
Name of HSA Owner: _____ (First, middle, last, prefix, suffix) Social Security Number: _____ Current Mailing Address: _____ (Address) _____ (City) (State) (Zip) Current Physical Residence Address (if different from Current Mailing Address listed above): _____ (Physical Address – we cannot accept a P.O. Box) _____ (City) (State) (Zip)	Home Number: () _____ - _____ Work Number: () _____ - _____ Cell Number: () _____ - _____ E-mail Address: _____ @ _____
Residence: <input type="checkbox"/> Own/buying <input type="checkbox"/> Rent <input type="checkbox"/> Live w/family/relatives <input type="checkbox"/> Other Date you moved into your current residence (month and year): _____ Previous Physical Residence Address (If less than 2 years at current address): _____ _____	
Employment status: <input type="checkbox"/> Employed <input type="checkbox"/> Self Employed <input type="checkbox"/> Homemaker <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed Employer: _____ Date employed (month and year): _____ Date of Birth: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
HDHP Coverage: <input type="checkbox"/> Family <input type="checkbox"/> Individual Mother's Maiden Name _____ (for identification purposes only)	

Applicant's Initials: _____
Last 4 Digits of SS#: _____

Please provide the information requested for at least one of the following types of identification:

- Current Driver's License
Issued by (state): _____ Issue date: _____ Expiration date: _____ ID No: _____
- Passport
Issued by (country): _____ Issue date: _____ Expiration date: _____ Passport No.: _____
- Current Federal Identification Card, such as those for employees of the military, Secret Service or IRS
Issued by (agency): _____ Issue date: _____ Expiration date: _____ ID No.: _____
- Current State-Issued Identification Card
Issued by (state): _____ Issue date: _____ Expiration date: _____ ID No.: _____
- Current Mexican Matricula Consular Identification:
Issuing office: _____ Issue date: _____ Expiration date: _____ ID No.: _____

2. CONTRIBUTION INFORMATION

- Contribution Amount: \$ _____ Tax Year: _____
- Contribution Type (select one):
- Regular
 - Rollover from an Archer Medical Savings Account
 - Rollover from an HSA
 - Transfer from an HSA
 - Transfer from an Archer Medical Savings Account
 - Contribution from an IRA
 - Return of Mistaken Distribution
 - Rollover from a Health Reimbursement Arrangement/Health Flexible Spending Account

3. FUNDING OF CONTRIBUTION

Please indicate your preferred method for funding your FirstBank Health Savings Account:

- _____
(Initials) One-time electronic transfer in the amount of \$ _____ to be made on the first day of _____
(Month/Year)
from my account at _____ Routing #: _____ Account #: _____
(Name of bank) (9-digit # on check) (Account #)
- _____
(Initials) **Monthly** electronic transfer in the amount of \$ _____ to be made on the _____^{1st} _____^{10th} _____^{20th} of each month.
(Choose only one option)
beginning _____ from my account at _____ Routing #: _____ Account # _____
(Month/Year) (Name of bank) (9-digit # on check) (Account #)
- _____
(Initials) Check enclosed in the amount of \$ _____
(payable to FirstBank)

4. DESIGNATION OF BENEFICIARY

At the time of my death, the primary beneficiaries named below will receive my HSA assets. If all of my primary beneficiaries die before me, the contingent beneficiaries named below will receive my HSA assets. In the event a beneficiary dies before me, such beneficiary's share will be reallocated on a pro-rata basis to the other beneficiaries that share the deceased beneficiary's classification as a primary or contingent beneficiary. If all of the beneficiaries die before me, my HSA assets will be paid to my estate. If no percentages are assigned to beneficiaries, the beneficiaries will share equally. If the percentage total for each beneficiary classification does not equal 100 percent, any remaining percentage will be divided equally among the beneficiaries within such class. This designation revokes and supersedes all earlier beneficiary designations which may apply to this AHSA.

A. Primary Beneficiary

Percentage	Name and Address of Beneficiary	SSN or Taxpayer ID No.	Relationship to HSA Owner
_____%	_____	_____	_____
_____%	_____	_____	_____
_____%	_____	_____	_____

B. Contingent Beneficiary

Percentage	Name and Address of Beneficiary	SSN or Taxpayer ID No.	Relationship to HSA Owner
_____%	_____	_____	_____
_____%	_____	_____	_____
_____%	_____	_____	_____

5. SPOUSAL CONSENT

____ (HSA Owner Initials) I am married. I understand that if I designate a primary beneficiary other than my spouse, my spouse must consent by signing below.

____ (HSA Owner Initials) I am not married. I understand that if I marry in the future, I must complete a new Designation of Beneficiary form, which includes the spousal consent documentation.

Spouse's consent required in community property states (AZ, CA, ID, LA, NV, WA, TX and WI) if spouse is not named as the sole beneficiary.

I am the spouse of the HSA owner. Because of significant consequences associated with giving up my interest in the HSA, the custodian has not provided me with legal or tax advice, but has advised me to seek tax or legal advice. I acknowledge that I have received a fair and reasonable disclosure of the HSA owner's assets or property, including any financial obligations for a community property state. In the event I have a legal interest in the HSA assets, I hereby give to the HSA owner such interest in the assets held in this HSA and consent to the beneficiary designation set forth in section 4 of this form.

X _____ Date: _____
Signature of Spouse

X _____ Date: _____
Electronic Signature

X _____ Date: _____
Signature of Witness (if required) (Witness cannot be a beneficiary of this HSA)

X _____ Date: _____
Electronic Signature

6. ADDITIONAL ACCOUNT SERVICES

A FirstBank HSA card, providing access to your Health Savings Account anywhere Visa is accepted as well as ATMs, will be issued in your name. If you have family coverage, you may also request additional cards for your spouse or dependents. Note: the first two Visa cards on the account (including yours) will be issued at no charge to you. Additional cards will be subject to an annual fee of \$7.50 per card.

Please issue additional Visa HSA cards in the following names:

7. SIGNATURES

If this HSA is being established with a regular contribution, and if Imerica approves my application, I represent that I will then be covered with a high deductible health plan (HDHP). I also represent that I am not covered by another health plan that provides any of the same benefits as this HDHP. I certify that the information provided by me on this Application is accurate, and that I will be provided a copy of the completed Application, Health Savings Custodial Account, and Disclosure Statement. I agree to be bound by the terms and conditions found in the Application, IRS Form 5305-C, Health Savings Custodial Account, Disclosure Statement, and amendments thereto. I confirm that I have not received any tax or other advice from FirstBank concerning this HSA, and I assume full responsibility for ensuring my continuing HSA eligibility and that all contributions which are made to this HSA are permissible under the current tax laws. I also agree that I am solely responsible for the tax consequences of any contributions to or withdrawals from this HSA, and I release and hold FirstBank harmless from any actions that I may take with regard to this HSA...

I authorize FirstBank to make inquiries that it feels may be necessary to determine my creditworthiness including, but not limited to, obtaining credit reports from credit reporting agencies and credit information from other sources from time to time. I authorize FirstBank and Imerica to exchange information about me and my accounts. I also authorize FirstBank to issue an automated banking card (Card) and personal identification number (PIN) to me for the HSA. I agree to use any card or account offered by FirstBank only in compliance with the terms and conditions set forth in the FirstBank Deposit Account and Electronic Banking Agreements, as well as all other account rules and regulations of FirstBank. I understand that a copy of these agreements, as well as a copy of FirstBank's Consumer Privacy Policy and Disclosure will be furnished to me within 10 days of the acceptance of my HSA application by FirstBank, and that a copy of these agreements will be made available to me in advance upon my request.

If I have requested an electronic transfer to fund my FirstBank HSA, I authorize FirstBank to transfer funds as indicated from an account in which I have an ownership interest. I agree to maintain sufficient funds or available credit in my account to enable FirstBank to make each transfer. If I do not, I understand that FirstBank may not process the transfer and will have no liability to me. I also understand that if FirstBank fails to make a transfer because of unintentional error despite reasonable precautions it has taken to prevent such an error, FirstBank will be liable only for direct damages and not for any consequential or punitive damages. I agree to follow any security procedures that FirstBank may require, either now or in the future, in connection with any transfer.

CERTIFICATION: Under penalties, my signature on this application certifies that the number shown on this form is my correct taxpayer identification number (TIN) and I am not subject to backup withholding because (1) I am exempt from backup withholding, (2) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (3) the IRS has notified me that I am no longer subject to backup withholding. CERTIFICATION required by the IRS. The IRS does not require your consent to any provisions on this document other than the certifications required to avoid backup withholding.

X _____	Date: _____
<i>Signature of Health Savings Account Owner</i>	
X _____	Date: _____
<i>Electronic Signature</i>	

WHAT HAPPENS NEXT?

1. Return this completed application to your broker, with your check to open the HSA if applicable.
2. Once your HDHP policy has been issued by Imerica, this application will be forwarded to FirstBank to open your HSA.
3. Within 10 days of opening the account, FirstBank will send you a welcome packet with additional information for managing your HSA.