

# Enrolling is Simple. Just Follow These 3 Easy Steps...

## **Step 1**

**COMPLETE THE APPLICATION IN BLUE OR BLACK INK.** Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department  
at: \_\_\_\_\_ fax: \_\_\_\_\_

## **Step 2**

**SELECT THE TYPE OF BILLING YOU WANT** – Pricing is based on a per day rate  
Be sure to remit your check for the entire premium with your application  
You may also choose to pay by credit card. See attached for the per day rate.

## **Step 3**

**PLEASE CONTACT OUR OFFICE FOR DELIVERY OPTIONS**

## **Please make your check payable to: Assurant Health**

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

**If you have questions please contact our office at:**

Thank you for choosing...



ASSURANT  
Health

Short Term Medical Enrollment Form				Time Insurance Company			ARIZONA
REQUESTED EFFECTIVE DATE			<b>Note:</b> Effective date is assigned by Time Insurance Company. The effective date is the later of: 1. The day after: a) the date this form is signed; b) the date this form is postmarked for mailing to Time Insurance Company; or c) the date we receive your enrollment request by electronic transmission in our home office, OR 2. If dates cannot be determined, the day we receive this form by mail. <b>The agent cannot assign an effective date different than this.</b>			CERTIFICATE/POLICY NUMBER	
MONTH	DAY	YEAR					
APPLICANT'S NAME (Print last, first, middle)			GENDER	BIRTH DATE	SOCIAL SECURITY NUMBER		
STREET ADDRESS			CITY, STATE, ZIP CODE				
SPOUSE'S NAME (if to be insured)			GENDER	BIRTH DATE	SOCIAL SECURITY NUMBER		
CHILDREN'S NAME (if to be insured)		BIRTH DATE	NAME		BIRTH DATE		
1.			2.		3.		
<b>Note: The plan cannot be issued if YES is answered to any questions. Under no circumstances can coverage become effective prior to the date this application is signed.</b>							
<b>Answer the following questions completely and accurately.</b>						YES	NO
1. Have/Are you, your spouse, or any person to be insured: ..... ◆ been denied insurance due to any health reasons that are still present?                      ◆ now pregnant, an expectant parent, in the process of adopting a child ◆ over 300 pounds if male, or over 250 pounds if female?    or undergoing infertility treatment?						<input type="checkbox"/>	<input type="checkbox"/>
2. For any of the following conditions within the last 5 years, have you or any person to be insured received any abnormal test results or medical or surgical treatment, or consulted a health care professional, or taken medication for: ..... ◆ heart disorder including but not limited to heart attack or chest pain?      ◆ AIDS or tested positive for HIV?                      ◆ diabetes? ◆ Emphysema?    ◆ stroke?    ◆ cancer or tumor? ◆ Crohn's disease, ulcerative colitis or hepatitis?                      ◆ kidney disorder, excluding kidney stones?                      ◆ alcoholism, chemical dependency, drug or alcohol abuse?						<input type="checkbox"/>	<input type="checkbox"/>
DEDUCTIBLE AMOUNT		PAYMENT OPTION AND LENGTH OF COVERAGE			RATE OF PAYMENT	TOTAL	
<input type="checkbox"/> \$ 500 <input type="checkbox"/> \$ 1,000 <input type="checkbox"/> \$ 2,500		<input type="checkbox"/> Single Payment - Total number of months needed _____ <input type="checkbox"/> Monthly Payment - Coverage is needed for: up to 6 months (30-180 days)			<input type="checkbox"/> 80%		
The undersigned attests that the information above is true to the best of his/her knowledge. The undersigned realizes that any false, or inaccurate statement or misrepresentation in the enrollment form may result in claim denial or contract rescission. Any person who injures, defrauds, or deceives any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. The undersigned understands that the plan applied for will not pay benefits for any expenses incurred on account of any condition which manifested itself before the effective date. The undersigned also understands that this is not a continuation of any previous medical plan, including any prior Short Term Medical plan. If I am self employed or an employee of an employer with 50 or fewer employees, I warrant premiums for this coverage are not: (1) Paid or reimbursed by my employer or, (2) To the best of my knowledge, treated as tax-deductible by my employer or me as related to an employer benefit plan (Internal Revenue Code sections 106,125,162 or 213).							
PRIMARY PHYSICIAN'S NAME (IF ANY)					PRIMARY PHYSICIAN'S TELEPHONE NUMBER		
APPLICANT'S SIGNATURE					TODAY'S DATE		
DAY TELEPHONE NUMBER			EVENING TELEPHONE NUMBER				
FORM 28786							
<b>Electronic Policy Option</b>							
I would like to receive my policy and the company's "Notice of Privacy Practice" via the Internet. .... <input type="checkbox"/> Yes <input type="checkbox"/> No					EMAIL ADDRESS		
To receive policy delivery via the Internet, you <u>must</u> provide your email address in the space to the right. ➡							
<b>Payment Information</b>							
Step 1: Select a Method of Payment: <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa <input type="checkbox"/> Check <input type="checkbox"/> Automatic charge to checking account (Only available with the Monthly Payment Option) <b><i>Please submit first month premium via check along with a separate voided check.</i></b>							
Important Reminders: The application fee is non-refundable. There will be no refund of premium after the 10-day free look period in the contract.							
<b>Step 2: Authorization</b> ◆ When selecting the single payment option with MasterCard/Visa: I authorize Assurant Health to charge my account for the Short Term Medical policy listed above. ◆ When selecting the monthly payment option with MasterCard/Visa or Automatic Charge to a checking account: I authorize Assurant Health to charge my account each month for the Short Term Medical policy listed above, until the end of the policy or until I request cancellation in writing. I understand I can request the charge be stopped if I notify Assurant Health seven days in advance of the charge occurring.							
Card # <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Exp. Date: ____ / ____      Authorized Amount \$ _____ (Insert Initial Premium Payment Amount)							
ACCOUNT HOLDER'S SIGNATURE				DATE		APP SOURCE	
AGENT NAME			AGENT ID #		CONFIRMATION CODE (HOME OFFICE USE ONLY)		
Assurant Health is the brand name for products underwritten and issued by Time Insurance Company. <span style="float: right;">(September 2008)</span>							