ASSURANT Health®

Client Tip Sheet

California

Accident Fixed-Benefit Coverage

Thank you for applying for Assurant Supplemental Coverage. Review the product brochure so you understand the benefits and limitations of the plan. Talk to your agent to make sure the plan you're applying for is best suited to your needs.

If you are applying for multiple products, you will need to complete a separate application for each one.

Follow these steps to enroll now!

1. Review the plan information in the brochure and with your agent. Determine which coverage is right for you: 24 Hour Coverage or Off-the-job Coverage; Level 1 or Level 2 Benefits.
2. Decide who you want to cover – just you; you and your spouse; you and your children; or you, your spouse and children.
3. Determine which Industry Class you are in. Rates are determined according to the Industry Class of the primary insured. Your agent can help you determine which Industry Class you should use, A, B, C or D/E.
4. Determine the appropriate rate for the coverage you select. Ask your agent to run an online quote or give you a rate sheet to submit with your application. AGENT: The Accident Fixed-Benefit Rate Sheet (30264) is available on Find a Form.
5. Start the application process by completing information about you and family members you would like to cover. Also complete the Insurance and Health History section.
6. For quick response to your application, fully complete the application with your agent, including:
   - All required questions
   - Requested effective date
   - Signatures
7. Complete the Billing Form indicating the method of payment.
8. Your agent will submit the completed forms and keep you updated on the status of your application.

AGENT: Leave a copy of the Outline of Coverage available in Find a Form, and the Important Notices page with the customer; fax all other pages to 414.299.6020

APPLICATION FORM FOR ACCIDENT-ONLY INSURANCE

TIME INSURANCE COMPANY

PLEASE PRINT IN BLACK INK

TYPE OF ACTIVITY

☐ New ☐ Change ☐ Conversion ☐ Reinstatement Policy Number _____

PERSON(S) PROPOSED TO BE INSURED

	Last Name	First Name	M.I.	Sex	Birth date MM/DD/YYYY	Social Security #	Height	Weight
(Applicant)								
(Spouse)								

Dependents

Relationship	Last Name	First Name	M.I.	Sex	Birth date MM/DD/YYYY	Full time student
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Resident Address _____
Street City State ZIP

Email Address _____

Home Phone ( ) _____ Business Phone ( ) _____ Best Time to Call _____

Name of Employer _____ Type of Business _____

Job Title _____

Job Duties _____

■ PROPOSED ADDITIONS TO AN EXISTING POLICY ONLY

☐ Add Spouse named above ☐ Add Dependent(s) named above

Reason(s) for addition(s) _____

Desired effective date for addition(s): _____

Complete the POLICY INFORMATION section below to indicate the type of coverage now desired. Complete the remainder of the application respective to any coverage applicable to the proposed addition.

BILLING – *to be completed by agent*

Payroll Deduction

☐ Monthly ☐ 28 day

☐ Other

Direct

☐ Monthly Credit Card ☐ Monthly EFT (Electronic Fund Transfer)

☐ Annual Billing

Employee No. _____ Dept. No. _____

Billable Premium $ _____ Premium Collected $ _____

Sit. Code _____

POLICY INFORMATION - *to be completed by agent*

CHECK COVERAGE DESIRED

☐ Individual only ☐ Individual and Spouse

☐ One-Parent Family ☐ Two-Parent Family

Occupation Class _____

Industry Code _____

Industry Class ☐A ☐B ☐C ☐D ☐E

	Modal Premium	If Payroll Deduction
☐ Level 1 Off the Job Accident Policy ☐ Level 2 Off the Job Accident Policy ☐ Level 1 24-hour Accident Policy ☐ Level 2 24-hour Accident Policy	$	☐ Pre Tax ☐ After Tax

Optional Rider Coverage	Number of Units*	Disability Benefit Period	Disability Elimination Period	Modal Premium	If Payroll Deduction
☐ Off the Job Accident Disability Rider (available for Applicant only)		☐ 6 months ☐ 12 months	☐ 0 days ☐ 7 days	$	After tax only
☐ On the Job Accident Disability Rider (available for Applicant only)		☐ 6 months ☐ 12 months	☐ 0 days ☐ 7 days	$	
☐ Sickness Disability Rider (available for Applicant only)		☐ 6 months ☐ 12 months	14 days only	$	
☐ Spouse Off the Job Accident Disability Rider (available for Applicant's spouse only)		6 months only	0 days only	$	
**NOTE: Each unit is equal to a $100 monthly benefit*				$	**TOTAL PREMIUM**

INSURANCE AND HEALTH HISTORY

1. Are you covered under another accident policy with:

			Is this a change of that coverage?
- Time Insurance Company	☐ No	☐ Yes, policy #_____	☐ No ☐ Yes
- Union Security Insurance Company	☐ No	☐ Yes, policy #_____	☐ No ☐ Yes
- John Alden Life Insurance Company.....	☐ No	☐ Yes, policy #_____	☐ No ☐ Yes

2. Has anyone proposed to be insured been charged with driving under the influence of alcohol or any narcotic within the last 12 months or been charged two or more times within the last five years? ..... ☐ Yes ☐ No

If "Yes", please list the name and relationship of each person _____

Anyone listed in response to 2 will not be covered under the policy or any riders.
If the applicant is listed, a policy will not be issued, in which case do not submit this application.

3a. Has anyone proposed to be insured been diagnosed with or treated for an injury, disease, or disorder of the back, the neck, or a joint by a member of the medical profession in the last 12 months? ..... ☐ Yes ☐ No

If you answered "Yes" to 3a, provide the details below and complete 3b.

Person's Name	Medical Conditions	Onset MM/YYYY	Surgery Performed? If "Yes", provide the type of procedure and date

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(Applicant)								
(Spouse)								

Dependents

Relationship	Last Name	First Name	M.I.	Sex	Birth date MM/DD/YYYY	Full time student
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Resident Address _____
Street City State ZIP

Email Address _____

Home Phone ( ) _____ Business Phone ( ) _____ Best Time to Call _____

Name of Employer _____ Type of Business _____

Job Title _____

Job Duties _____

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2. Has anyone proposed to be insured been charged with driving under the influence of alcohol or any narcotic within the last 12 months or been charged two or more times within the last five years? ..... ☐ Yes ☐ No

If "Yes", please list the name and relationship of each person _____

Anyone listed in response to 2 will not be covered under the policy or any riders.
If the applicant is listed, a policy will not be issued, in which case do not submit this application.

3a. Has anyone proposed to be insured been diagnosed with or treated for an injury, disease, or disorder of the back, the neck, or a joint by a member of the medical profession in the last 12 months? ..... ☐ Yes ☐ No

If you answered "Yes" to 3a, provide the details below and complete 3b.

Person's Name	Medical Conditions	Onset MM/YYYY	Surgery Performed? If "Yes", provide the type of procedure and date

3b. Has anyone proposed to be insured been prescribed any medication or taken any prescription medication (not including prescription contraceptives) in the last six weeks? ..... ☐ Yes ☐ No

If you answered "Yes" to 3b, provide the details below.

Person's Name	Medication Name	Dosage	Frequency	Date First Prescribed	Reason

PROPOSED POLICYOWNER'S AGREEMENT

I represent to the best of my knowledge and belief, that all statements and answers on this application form are complete and true. The application form and any amendments shall be the basis for the contract. I also agree that:

The policy, if approved by Time Insurance Company, will have the Effective Date recorded on the Policy Schedule by Time Insurance Company. I acknowledge receiving the following, if required:

- Fair Credit Reporting Act Pre-Notification
- Outline of Coverage (if required by state law)
- Abbreviated Notice of Insurance Information Practices
- Notification regarding the Medical Information Bureau
- Guide to Health Insurance for People with Medicare

I understand that the premium amount listed on this application represents the premium amount that my employer will remit on my behalf if I select payroll deduction as the method of premium payment. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me by the agent.

I have read, or had read to me, the completed application and realize that policy issuance is based upon statements and answers provided and any other pertinent information that may be required for proper underwriting. The answers are complete and true to the best of my knowledge and belief. I understand and acknowledge that any fraudulent statement or material misrepresentation on the application and/or any amendments may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provisions in the policy.

Authorization

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, an insurance company or reinsurer, the Medical Information Bureau; consumer reporting agency; or employer, to give to Time Insurance Company and any of its reinsurers or legal representative, information about my physical or mental condition; character, general reputation; habits; finances; insurance history; occupation; and hobbies upon presentation of this authorization for the purpose of obtaining insurance. I understand that I (or an authorized representative) may ask for a copy of this authorization.

A photographic copy of this authorization shall be as valid as the original. The authorization shall be valid for 30 months from the date it is signed.

Signature of proposed Policyowner	Date signed	Time Signed ☐A.M. ☐P.M.	City & State

Beneficiary _____ Relationship _____

AGENT INFORMATION AND REVIEW

Agency Name and Time Agency Number Sonoma Valley Insurance Agency, Inc.

Agent Name and Time Agent Number John M. Caris 000822GV000001

Agent Phone Number (707) 935-6294 x103 Agent Fax Number (707) 935-3602

General Agent is located in the state of CA

I certify that:

- ☐ I personally saw the applicant. The applicant was asked each required question and the answer truly and accurately recorded on the application in the respective response area. The answers are true to the best of my knowledge.
- ☐ The application was completed by the applicant or applicant's representative and the answers are true to the best of my knowledge.

Licensed Resident Agent's Signature

Date Signed

Initial here if you witnessed the signing of this form by the proposed Policyowner.

For policies that provide benefits for expenses incurred for an accidental injury only

IMPORTANT NOTICE TO PERSONS ON MEDICARE:
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE.

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.
This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplemental Insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them.
These include: hospitalization; physician services; and, other approved items and services.
This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

BEFORE YOU BUY THIS INSURANCE

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

FAIR CREDIT REPORTING ACT AND PRIVACY PRE-NOTIFICATION

Thank you for considering Time Insurance Company as your insurance carrier. Your enrollment form will be processed as quickly as possible. Public Law 91-508 and state privacy acts require that we advise you that an investigative consumer report may be made in connection with this application form which will provide applicable information concerning character, general reputation, personal characteristics and mode of living. The information for this report may be obtained through telephone or personal interviews with you, your friends, neighbors and associates. You may request an interview in connection with the preparation of the report. Upon written request, you are entitled to receive a copy of the report.

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

Information collected by us and used to issue an insurance policy or certificate may be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, P.O. Box 624, Milwaukee, WI 53201-0624.

FRAUD WARNING

Any person who, with intent to defraud or knowingly presents false information on an application for insurance, or files a false or fraudulent claim for payment of a loss or benefit, is guilty of insurance fraud. Any person found guilty of insurance fraud may be subject to fines and confinement in prison.

NOTIFICATION REGARDING THE MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-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 form from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. Time Insurance Company or its reinsurers may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may also apply for life, disability or medical insurance, or to whom a claim for benefits may be submitted.

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health insurance company. To get an interpreter or to ask about written information in Spanish, first call your insurance company's phone number at 1-800-800-1212. Someone who speaks Spanish can help you. If you need more help, call the Department of Insurance Hotline at 1-800-927-4357.

IMPORTANTE: Puede obtener la ayuda de un interprete sin costo alguno para hablar con su medico o con su compania de seguros. Para obtener la ayuda de un interprete o preguntar sobre informacion escrita en espanol, primero llame al numero de telefono de su compania de seguros al: 1-800-800-1212. Alguien que habla espanol puede ayudarle. Si necesita ayuda adicional, llame a la linea directa del Departamento de seguros al: 1-800-927-4357.

BILLING

Complete the details below for the Primary applicant (PLEASE PRINT):

_____

Last Name First Name MI

You have four billing methods to choose from:

1. **Monthly payroll deduction (worksite billing)**

   ➜ Assigned account number, if known: _____

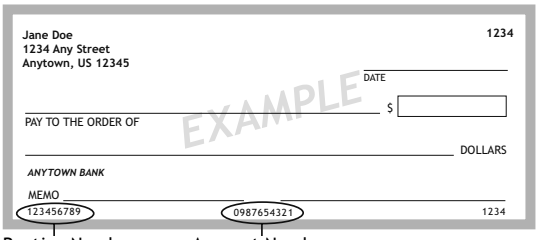
   Note to agent: this option requires the worksite to have 5 or more issued policies and a Worksite Billing Account Agreement Form on file.

2. **Electronic Funds Transfer (EFT)/Check-O-Matic** ➜ Choose how often: ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

   ➜ To begin EFT/Check-O-Matic withdrawals:
   Select a desired withdrawal day 1-28:_____

   Bank Name: _____
   City:_____ State:_____
   Routing number: _____ _____ _____ _____ _____ _____ _____ _____ _____
   Account number: _____

   ➜ To add this policy to an existing EFT/Check-O-Matic:
   Existing EFT/COM Number: _____
   Associated Policy Number: _____



Routing Number *9 digits* Account Number

AUTHORIZATION FOR EFT/CHECK-O-MATIC BILLING — please sign below
I (we) hereby authorize Time Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, indicated above, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Accountholder Signature: _____ Date: _____

3. **Credit card** ➜ Choose how often: ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

AUTHORIZATION FOR CREDIT CARD PAYMENTS — please sign below
I authorize Time Insurance Company to charge my account for the individual supplemental insurance policy.
I understand there will be no refund of premium after the 30-day free look in the contract

Card number: _____ _____ _____ _____ - _____ _____ _____ _____ - _____ _____ _____ _____ - _____ _____ _____ _____

Card type: ☐ VISA ☐ MasterCard

Expiration date: _____/_____

Name as it appears on card: _____

Cardholder billing address if different than resident address: _____

Cardholder signature: _____ Date:_____

4. **Bill me directly:** ➜ Choose how often: ☐ Quarterly ☐ Semi-Annual ☐ Annual

If your billing address is different than your home address, please enter it here:

Billing Address: _____
(Street) (City) (State) (ZIP)

Name of person paying, if different:_____