ASSURANT
Health

Paper Enrollment Checklist

When submitting paper enrollment forms, use this easy checklist to ensure the fastest possible processing. ***Check it out - then check it off!***

Provide the following to the your clients.

☐ **Quote:** Verify it has been reviewed by your client.

☐ **Outline of coverage:** Verify it has been reviewed by your client.

Mail the following to Assurant Health.

☐ **Assurant Health Enrollment Form (Form 30300-WA):** Include one form listing all family members applying for coverage.

☐ **Standard Health Questionnaire (SHQ):** Include one SHQ for each family member applying for coverage.

- List any applicants who are exempt from completing the SHQ.
  - ______________________________
  - ______________________________
  - ______________________________
- If a family member is exempt from completing the SHQ for medical coverage, but the policy applied for is the Assurant® Select 5000 Outpatient Prescription Policy, exempted family members must still complete the SHQ. Please list their names.
  - ______________________________
  - ______________________________
  - ______________________________

☐ **Health Replacement Form (Form 15416):** Applicable for applicants replacing other individual coverage.

☐ **HSA Adoption Agreement (Form 28747):** Establishes an HSA Tools account for applicants approved for the Assurant HSA Plan.

☐ **This Checklist**

All documents can be downloaded from Find a Form at www.assuranthealthsales.com.

Mail all documents to: Assurant Health
501 West Michigan
P.O. Box 692
Milwaukee, WI 53201-0692

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Washington State Enrollment Form for Medical and/or Prescription Insurance for Individuals and Families

PLEASE PRINT IN BLACK INK

AGENT/AGENCY INFORMATION

Agent Name: ______________________ Phone Number: ______________________

Agent Number: ______________________ E-mail Address: ______________________

Key Agency Contact: ______________________ Agency Name: ______________________

Fax Number: ______________________ Agency Number: ______________________

TYPE OF ACTIVITY *(Please check appropriate boxes.)*

☐ **NEW ENROLLMENT APPLICATION** Requested effective date: ______________________(month) ☐ 1st ☐ 15th
(The requested date cannot be more than 60 days after the completed enrollment forms are received.)

If we receive complete enrollment materials by the 15th of the month, approved coverage can be effective as early as the 1st of the following month. If we receive complete enrollment materials by the 31st of the month, approved coverage can be effective as early as the 15th of the following month. Check with your agent for more details.

If not a new enrollee, check the appropriate box and list the affected policy number.

☐ **CHANGE/ADDITION TO AN EXISTING POLICY. POLICY #** ______________________

☐ Internal Replacement ☐ Conversion (over age dependent/divorce)

☐ Adding Dependent ☐ Policy/Benefit Change to an Existing Policy *List Type Of Change Requested:* ______________________

☐ Removal of Tobacco Rates ☐ Reinstatement of Coverage

PERSON(S) TO BE INSURED

Attach a separate sheet, signed and dated, if additional space is needed for other dependent children.

	Name *Last* *First* *MI*	Sex	Age	Birthdate *(MM/DD/YY)*	Tobacco use within the past 12 months? *Yes*	*No*	Social Security Number
1. PRIMARY					☐	☐	
2. SPOUSE					☐	☐	
3. DEPENDENTS *(list relationship)*	Name *Last* *First* *MI*	Sex	Age	Birthdate *(MM/DD/YY)*	Full-time Student? *Yes*	*No*	Social Security Number
a.					☐	☐	
b.					☐	☐	
c.					☐	☐	
d.					☐	☐	

4. Resident Address: ______________________
(NO P.O. BOXES) *(Street)* *(City)* *(State)* *(ZIP)*

5. County of Residence: ______________________

I represent that I am a resident of Washington State and that my permanent home and place of habitation is within Washington State for purposes other than obtaining insurance. . . . . ☐ Yes ☐ No

6. Mailing Address: ______________________________
(If different than resident address) *(Street)* *(City)* *(State)* *(ZIP)*

7. Daytime Number: (_____) ______________________ 8. E-mail Address: ______________________

9a. Are any of the proposed insureds covered by any type of medical insurance? . . . . ☐ Yes (Complete section 9b) ☐ No (Go to question 10)

9b. *Attach a separate sheet, signed and dated, if additional space is needed for other dependent children.*

Proposed Insured	Insurance Company Name	Group or Individual	Type of Coverage*	Deductible	Effective Date *(MM/DD/YY)*	Termination Date *(MM/DD/YY)*	Is this coverage being replaced by proposed coverage?
Primary							
Spouse							
Dependent a.							
Dependent b.							
Dependent c.							
Dependent d.							

*For example, major medical, hospital surgical, WSHIP, or cancer.

10a. Are any of the proposed insureds eligible for Medicare? *(If yes, complete question 10b.)* ....☐ Yes ☐ No

10b. Name(s) ______________________________

BILLING

Monthly Electronic Funds Transfer (EFT)/Check-O-Matic (COM)

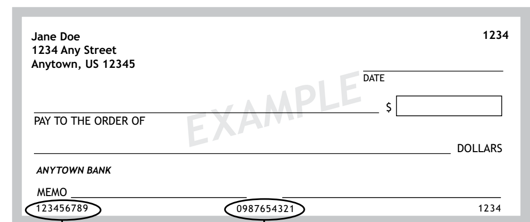
➜ **To begin withdrawals:**
The initial draft will occur on the day your coverage is approved. Subsequent drafts will occur on the same day of the month as your effective date.

Bank name: ______________________

City: ______________ State: ____________

Routing number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Account number: ______________________



Routing Number ***9 digits*** Account Number

➜ **To add this policy to an existing Electronic Funds Transfer (EFT)/Check-O-Matic (COM):**

Existing EFT/COM number: ______________________

Associated policy number: ______________________

Electronic Funds Transfer (EFT)/Check-O-Matic (COM) *(Complete authorization below)*

I (we) hereby authorize Time Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, indicated on the other side, 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 Signed

HIPAA ELIGIBILITY

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), certain individuals have a guaranteed right to an individual plan without a pre-existing exclusion. In order for Time Insurance Company to determine whether you or anyone applying for coverage is entitled to such a plan, please review the following and indicate whether ALL of the following statements are true at the time you or anyone to be insured apply for individual coverage:

- You have at least 18 months of continuous creditable coverage without any break in coverage greater than 63 days.
- Your most recent coverage was under a group plan, a governmental plan or a church plan.
- You are not covered under another group health plan.
- Your most recent coverage was not cancelled because you did not pay premiums or because you committed fraud.
- You are not currently eligible for Medicare or Medicaid.
- You have exhausted any continuation of coverage (COBRA or state continuation) for which you were eligible.

☐ **No, I or anyone to be insured do not meet one or more of the above requirements.**

☐ **Yes, I or anyone to be insured meet all of the above requirements. (A Certificate of Creditable Coverage is needed for proof.)**

EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT

You understand and agree that you are applying for individual health insurance for you (and your family). You further understand that this application for health insurance will be fully medically underwritten based on your responses to the Washington Standard Health Questionnaire and to other eligibility requirements permitted under Washington laws, and that coverage is not guaranteed . You are personally paying the entire premium for this health insurance coverage. Your employer is not contributing in any way to the payment of premium, either directly or indirectly.

Do you agree with this statement? . . . . ☐ Yes ☐ No

AUTHORIZATION

My enrollment form, and any amendments including but not limited to my complete and accurate Standard Health Questionnaire, if required, shall be the basis for the contract.

I understand the insurance coverage(s) is subject to underwriting. The insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company. The first full premium must be paid. Coverage(s) will become effective on the later of: A) The requested effective date; or, B) the 1st of the following month if completed enrollment materials are received by the 15th of the month; or, C) the 15th of the following month if completed enrollment materials are received by the 31st of the month. A change in the health of the proposed insured(s) after the completion of the enrollment form and/or Washington Standard Health Questionnaire and before the delivery of the contract may affect my eligibility for insurance with the company. I understand and agree that any information I provide through this application process may be shared with persons necessary to facilitate issuing coverage, including but not limited to my agent or broker. If any of these conditions are not met, Time Insurance Company has the right to rescind and/or terminate its offer of coverage(s) and the full extent of its liability shall be limited to the sum received.

I agree that a photocopy of this authorization shall be valid for two years from the date signed.

I understand that the following authorizations are required in order to enable Time Insurance Company to verify representations made on the Standard Health Questionnaire in the investigation of fraud, or to determine a pre-existing condition relating to me, and/or my minor children, during the course of my medical or other coverage requested in this application. This authorization is used in the investigation of claims submitted and not during the underwriting process for medical coverage, although claims experience already on file with the company may be used at the time of underwriting to verify accuracy of representations on the Standard Health Questionnaire. If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for enrollment.

I hereby authorize any health care provider or medically related facility, pharmacy, pharmacy benefit manager or pharmacy related facility, consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information including information regarding employment, other insurance coverage, personal information, medical or pharmacy care, advice, treatment, or medication use as may be requested to Time Insurance Company, its legal representative or any medical records retrieval service Time Insurance Company may engage, including, but not limited to, Examination Management Services, Inc.(EMSI).

This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs.

I further authorize Time Insurance Company to disclose any and all such information to any medical records company engaged by Time Insurance Company, including but not limited to EMSI and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations.

I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, P.O. Box 3050, Milwaukee, WI 53201-3050. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.

Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: denial of my application, declination of enrollment, or, if insured, when I am no longer an insured of Time Insurance Company.

I acknowledge receiving the notification regarding the Abbreviated Notice of Insurance Information Practices and the Outline(s) of Coverage for the insurance for which I am applying.

I acknowledge that I have read the completed enrollment form. I attest that all statements and answers on this enrollment form and the Washington Standard Health Questionnaire (if required) are complete, true and correct. I understand and acknowledge that any fraudulent statement or material misrepresentation or omission on the enrollment form, recorded Authorizations, personal health history and/or any amendments may result in claim denial or contract(s) rescission and/or termination, subject to the time limit on certain defenses or incontestability provisions of the contract(s).

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

____
Signature of Primary Proposed Insured

____
Signature of Spouse or Other ***(if proposed to be insured)***

____
Signature(s) of Other Dependent(s) 18 or Over
(if proposed to be insured)

____
Guardian's Signature ***(if primary proposed insured is a minor)***

Premium Amount Sent $ ________________________

____________________ A.M./P.M. ____________________
Date &Time signed **City & State signed in**

Attention: (Agent)
I have reviewed this enrollment form to ensure that all required items have been completed.

To the best of knowledge, there ☐ **IS** ☐ **IS NOT** a replacement of medical insurance involved in this transaction.

____
Licensed Resident Agent's Signature

____
Print Agent's Name

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

STANDARD HEALTH QUESTIONNAIRE EXCEPTIONS & WAIVER DOCUMENTS

	Primary	Spouse	Enter dependent information in same order as page 1.			
			a.	b.	c.	d.
11. Your medical insurance ended during the last 90 days for any of the following reasons:						
a) You have used up all of your available COBRA coverage.	☐	☐	☐	☐	☐	☐
(A Certificate of Creditable Coverage is needed for proof.)						
b) Your former employer, who provided you with health coverage has gone out of business while you were on COBRA coverage.	☐	☐	☐	☐	☐	☐
(A Certificate of Creditable Coverage is needed for proof.)						
c) You changed residence from one part of Washington state to another part where your current health plan is not offered.	☐	☐	☐	☐	☐	☐
(A copy of your utility bill with the prior address dated within 90 days of the date of this application is needed for proof.)						
12. You had a newborn child, and/or had a child placed with you for adoption (regardless of age) during the last 60 days who you want to add to your existing policy.	☐	☐	☐	☐	☐	☐
(A copy of adoption/placement papers is needed for proof.)						
13. You have been covered by a group health plan that is exempt from COBRA (provided under 29 U.S.C. 1161 et.seq.), including church plans, for at least 24 continuous months and						
a) You will lose coverage under that plan with the next 90 days or	☐	☐	☐	☐	☐	☐
b) You lost coverage with the past 90 days.	☐	☐	☐	☐	☐	☐
(A letter from the employer indicating type and dates of coverage is needed for proof.)						
14. Your doctor or other health care provider stopped being a part of the provider network on your current individual medical plan and	☐	☐	☐	☐	☐	☐
a) Your doctor or provider is on the new health plan you are applying for, and						
b) You must have had some service from that provider during the 12 months before he or she left your current health plan and						
c) You must submit your application to the new health plan within 90 days from the day your provider left your current health plan's network.						
(A letter of verification from the provider or insurer is needed for proof.)						
15. You've been enrolled in the Washington State Basic Health Plan (BHP) for at least 24 continuous months and						
a) you will lose your BHP coverage within the next 90 days or	☐	☐	☐	☐	☐	☐
b) You lost your BHP coverage within the past 90 days.	☐	☐	☐	☐	☐	☐
(A letter or coverage certificate from the Washington State BHP indicating dates of coverage is needed for proof.)						

If any of the exceptions apply provide proof as specified above (for each applicant). A State Health Questionnaire is not required for the applicant that meets one or more of the exceptions above, **except** if you applied for the Select 5000 Pharmacy Plan in addition to the medical coverage, then **you must complete** the Standard Health Questionnaire.

	Primary	Spouse	a.	b.	c.	d.
16. No exceptions apply and a Standard Health Questionnaire has been completed for each person to be insured. All questionnaires are included.	☐	☐	☐	☐	☐	☐

IMPORTANT NOTICES — LEAVE WITH CUSTOMER

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances 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, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.

FRAUD NOTICE

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.

PRIVACY

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on enrollment forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.

Washington State Benefit Proposal Form
Medical Insurance for Individuals and Families

PLEASE PRINT IN BLACK INK

AGENT & PRIMARY PROPOSED INSURED INFORMATION

This is a supplemental Plan Selection form. Submit this form along with Washington Enrollment Form 30300-WA.
Please complete the Agent and Primary Proposed Insured information below as it appears on Enrollment Form 30300-WA.

Agent Name: ____________________

Agent Number: ____________________

Name of Primary Proposed Insured: ____________________

To be eligible for the plans listed below, each Applicant must meet the underwriting criteria based on completion of the Washington State Standard Health Questionnaire (if required).

Outlines of Coverage summarizing the main benefits, exclusions and limitations are available for each of the plans listed below and will be provided at your request. Once you have selected a plan as part of this application, an Outline of Coverage specifying the coverage type and benefit levels you choose will be provided.

MEDICAL PLAN OPTIONS

Choose the Plan. Then select from the choices of Deductible, Coinsurance Rate and Lifetime Maximum available for the plan. Deductible is not included in the Out of Pocket Amount shown. Then enter the rate for the plan selected.

☐ **Washington Catastrophic Plans** *(Non-HSA compatible)*

Choose an in-network Deductible:

☐ $ 2,000 Individual / $ 4,000 Family
☐ $ 3,000 Individual / $ 6,000 Family
☐ $ 5,000 Individual / $10,000 Family
☐ $10,000 Individual / $20,000 Family

Choose an in-network Coinsurance Rate:

☐ You pay in-network 25% coinsurance up to $ 2,500
☐ You pay in-network 25% coinsurance up to $ 5,000
☐ You pay in-network 50% coinsurance up to $ 5,000
☐ You pay in-network 50% coinsurance up to $10,000
☐ With $2,000 Deductible only: You pay in-network 50% coinsurance up to $20,000

Choose a Lifetime Maximum Benefit level:

☐ $3,000,000 or ☐ $6,000,000

☐ **Washington HSA Qualified Plan**
This plan is only available with a $2,700 in-network Individual Deductible ($5,400 Family).
You pay in-network 20% coinsurance up to $2,000 Individual Out-of-Pocket max.

Choose a Lifetime Maximum Benefit level:

☐ $3,000,000 or ☐ $6,000,000

☐ **Washington Comprehensive Plan** *(Non-HSA compatible)*
This plan is only available with a $1,500 in-network Individual Deductible ($3,000 Family).
You pay in-network 25% coinsurance up to $7,500 Individual Out-of-Pocket max. $2,000,000 Lifetime Maximum Benefit.
Prescription coverage is included in the plan at $2000 per Covered Person

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NOTE: If you later decide to change to another individual medical health plan, the period of time you are covered under a **Catastrophic Health Plan may not be credited towards the new health plan's pre-existing condition waiting period.*

OUTPATIENT PRESCRIPTION PLAN OPTIONS

☐ **Outpatient Prescription Drug Policy**
This plan is available as a stand alone prescription benefit policy and is also available to supplement Health Plans that do not include prescription drug benefits.

Note: The Outpatient Prescription Drug Policy is not available with the Comprehensive or HSA Plans. This coverage is subject to underwriting, and you may not qualify for the selected plan.

Choose a Prescription Benefit level:

☐ Basic 500: Offered with a $15 Generic Drug Copayment, $25 Brand Drug Copayment and you pay 50% brand coinsurance. Plan benefits are subject to: An annual maximum of $500.

☐ Select 5000: Offered with a $15 Generic Drug Copayment, $25 Brand Drug Copayment and you pay 25% brand coinsurance. Plan benefits are subject to: A brand drug maximum is $5000 per year, with unlimited coverage for generic drugs.

OUTPATIENT PRESCRIPTION DRUG PLAN

Monthly Premiums Table and Quote Form

Rates effective from 1st of the month through the end of the month indicated

	Oct - Dec, 2008	Jan - Mar, 2009	Apr - June, 2009	July - Sep, 2009	Oct - Dec, 2009
ASSURANT® BASIC 500					
<25	$11.00	$11.26	$11.54	$11.81	$12.10
25-29	$13.00	$13.31	$13.64	$13.96	$14.30
30-34	$15.00	$15.36	$15.74	$16.11	$16.50
35-39	$16.00	$16.38	$16.78	$17.18	$17.60
40-44	$18.00	$18.43	$18.88	$19.33	$19.80
45-49	$19.00	$19.46	$19.93	$20.41	$20.90
50-54	$20.00	$20.48	$20.98	$21.48	$22.00
55-59	$22.00	$22.53	$23.08	$23.63	$24.20
60-64	$24.00	$24.58	$25.18	$25.78	$26.40
Child	$8.00	$8.19	$8.39	$8.59	$8.80
ASSURANT® SELECT 5000					
<25	$14.00	$14.50	$15.02	$15.55	$16.11
25-29	$17.00	$17.61	$18.24	$18.89	$19.57
30-34	$19.00	$19.68	$20.39	$21.11	$21.87
35-39	$23.00	$23.83	$24.68	$25.55	$26.47
40-44	$28.00	$29.01	$30.04	$31.11	$32.23
45-49	$35.00	$36.26	$37.56	$38.89	$40.29
50-54	$43.00	$44.55	$46.14	$47.77	$49.49
55-59	$52.00	$53.87	$55.80	$57.77	$59.85
60-64	$61.00	$63.20	$65.45	$67.77	$70.21
Child	$10.00	$10.36	$10.73	$11.11	$11.51

Calculating a Rate

1. Use the table that corresponds to the plan selected, either Assurant Basic 500 or Assurant Select 5000.
2. Find the rate for the Primary Insured for the plan selected (for effective date desired) and enter it in the Primary Insured line below.
3. If the quote includes a spouse, find the spouse's age and the rate indicated according to the effective date desired. Enter it below in the Spouse line.
4. If there are dependent children, find the child rate for the appropriate effective date rate, and enter it below in the Child line. Enter the total number of children to be covered. Multiply the rate times the number of children to get the Monthly Total Child Rate.
5. Add all results together to get the total monthly premium for prescription drugs.

Example

Assurant Basic 500 Plan, 4 member family, December 1, 2008 rates.

Primary Insured (age 30)	$ 15.00
Spouse (age 33)	$ 15.00
Child $ 8.00 x 2	$ 16.00
Monthly Prescription Drug Plan	$ 46.00

Outpatient Prescription Drug Plan QUOTE

Primary Insured	$____.____
Spouse	$____.____
Child $____.____ x ____	$____.____
Monthly Prescription Drug Plan	$________

If requesting the prescription drug coverage only, please submit this Quote Form along with a completed enrollment form to:

ASSURANT HEALTH
501 West Michigan
P.O. Box 692
Milwaukee, WI 53201-0692

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Form 29931 (7/2008)

Policy #

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

Will this insurance replace any other accident and sickness insurance presently in force? ❑ Yes ❑ No, If yes, see below.

According to your statement you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by TIME INSURANCE COMPANY. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above “Notice to Applicant” was delivered to me on:

____
(Date)

____
(Applicant’s Signature)

PLEASE FAX TO: 414-299-6020

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company.