# 1,2,3 enrollment

## Determine eligibility

**1** Decide whom to cover and determine eligibility:

- In general, persons between the ages of 30 days and 64 years, 11 months, are eligible. Dependents may be eligible up to age 18, or age 24 if full-time students. Age requirements can vary by state. See the back of the Rate Sheet for your state eligibility information.
- U.S. and foreign residents are both eligible.
- Answer the health questions on the enrollment form. You will not be eligible for coverage if you answer "yes" to any health question. Plans do not cover pre-existing conditions.* See the pre-existing condition definition on the back of the Rate Sheet.

*If you have a pre-existing condition, our Individual Medical plans or COBRA may be a better coverage option. Talk to your agent.

## Design your plan

**2** Choose your plan details and payment options:

- **Deductible** — the amount you pay before the plan pays. Choosing a higher deductible lowers your premium but means you pay more out of pocket for medical expenses.
- **Coinsurance** — the percent of medical expenses we pay and you pay after you pay your deductible. For example, for plans with 80/20 coinsurance, you pay your deductible + 20% of the next $10,000 in covered charges. After that we pay 100% of covered charges up to the $2 million lifetime maximum.
- **Length of coverage** — one month (30 days) up to six months (180 days).
- **Payment options**
  - Monthly payments give you flexibility — pay as you go!
  - Single payment is cost saving — pay one time and save 20%!

  Payment is required at the time of enrollment.

## Enroll

**3** Calculate your premium using the Rate Sheet and complete the enrollment form (forms enclosed).

**Note:** Before you enroll, please see the back of the Rate Sheet for important state-specific information.

### Premium Refunds

If you're not completely satisfied with your Short Term Medical plan, simply call and cancel your coverage within 10 days of delivery and receive a full premium refund, no questions asked. The one-time application fee is not refundable.

# Georgia

## Chart 1 - Primary Insured/Spouse Daily Rate

| AGE | Deductible | | |
|---|---|---|---|
| | $1,000 | $2,500 | $3,500 |
| 0-14 | 1.25 | 0.95 | 0.80 |
| 15-19 | 1.55 | 1.25 | 1.10 |
| 20-24 | 1.50 | 1.10 | 0.95 |
| 25-29 | 1.38 | 0.97 | 0.95 |
| 30-34 | 1.41 | 1.10 | 1.05 |
| 35-39 | 1.78 | 1.26 | 1.15 |
| 40-44 | 2.11 | 1.52 | 1.31 |
| 45-49 | 2.51 | 1.75 | 1.50 |
| 50-54 | 3.36 | 2.51 | 2.16 |
| 55-59 | 4.42 | 3.26 | 2.81 |
| 60-64 | 7.08 | 5.07 | 4.37 |

## Chart 2 - Dependent Child Daily Rate

| AGE | Deductible | | |
|---|---|---|---|
| | $1,000 | $2,500 | $3,500 |
| Per Child | 0.96 | 0.60 | 0.60 |

## Chart 3 - Zip Code Factor

| Zip Code | |
|---|---|
| 300-303, 311 | 2.10 |
| All Other GA | 2.33 |

## Chart 4 - Deductible and Coinsurance Factor Table

| | Deductible | | |
|---|---|---|---|
| | $1,000 | $2,500 | $3,500 |
| 50% | .80 | .80 | .80 |
| 80% | 1.00 | 1.00 | 1.00 |
| 100% | N/A | 1.25 | 1.25 |

## Premium Calculation Instructions

*Refer to charts on the left when figuring the premium*

| | Single Payment | Monthly Payment |
|---|---|---|
| **Step 1.** Choose a payment option - single or monthly | | |
| **Step 2.** List each applicant's daily rate. Rate chart is set up by age and deductible*.<br>a) Primary insured rate .....<br>b) Spouse rate .....<br>(see Chart 1)<br>**SUBTOTAL =** | _____<br>+_____<br>_____ | _____<br>+_____<br>_____ |
| **Step 3.** List the per child rate (Chart 2). Enter the number of dependent Child(ren). Multiply the rate by the number of children.<br>**SUBTOTAL =** | _____<br>x_____<br>_____ | _____<br>x_____<br>_____ |
| **Step 4.** Add the subtotal from Step 2 & 3.<br>= | _____ | _____ |
| **Step 5.** Monthly Factor. Multiply by the subtotal in Step 4.<br>**SUBTOTAL =** | x 1.00<br>_____ | x 1.28<br>_____ |
| **Step 6.** Enter Zip Code Factor (Chart 3). Multiply by subtotal in Step 5.<br>**SUBTOTAL =** | x_____<br>_____ | x_____<br>_____ |
| **Step 7.** Enter the number of days of coverage. Multiply the number of days by the subtotal in Step 6.<br>**SUBTOTAL =** | x_____<br>Minimum 30 Maximum 180<br>_____ | x 30<br>_____ |
| **Step 8.** Coinsurance Enter the Coinsurance Factor (Chart 4) Multiply by the subtotal in step 7.<br>**SUBTOTAL =** | x_____<br>_____ | x_____<br>_____ |
| **Step 9.** Application Fee** ***(Non refundable)*** Add fee to subtotal in Step 8.<br>**TOTAL =** | + $25.00<br>_____ | + $25.00<br>_____ |
| *Choose one deductible amount per policy<br>** Application fee is added to first month's premium only | **Enter this amount on the enrollment form in the box marked TOTAL** | |

Georgia

**Applying for another STM plan**

Short Term Medical is temporary coverage, so plans cannot be renewed like permanent insurance. However, when your plan expires, you many apply for another plan if you have not had a total of more than **730 days of short-term coverage** without a **64-day coverage gap.** When your plan expires, you may be eligible for another plan depending on how long you have been covered by Short Term Medical plans. If you are issued a new Short Term Medical plan, the new plan will not provide benefits for any conditions or symptoms that existed during the previous plan.

Keep in mind that short-term plans are not meant to be a substitute for permanent health insurance coverage. An Assurant Health Individual Medical plan may be a better option.

**Eligibility**

To be considered for coverage, each person must be between the age of 30 days and 64 years, 11 months. To be considered dependents, your child(ren) must be age 18 or younger, or 24 or younger if full-time student.

**Extended protection**

If you become injured or ill while your plan is in force

- your benefits may be extended at no additional cost for up to 12 months if you are hospitalized.
- you can receive up to $1,000 in benefits at no additional cost for up to 60 days if you have a nondisabling condition.

**Pre-existing conditions**

Short Term Medical plans provide coverage for unexpected illnesses and injuries, meaning they do not cover pre-existing conditions. A pre-existing condition is a medical condition due to sickness or injury

- for which you received medical treatment or advice during the 5-year period immediately prior to your Short Term Medical effective date, regardless of whether the condition was diagnosed or not; or
- that produced signs or symptoms within the 5-year period immediately prior to your Short Term Medical effective date. The signs or symptoms either must have allowed one knowledgeable in medicine to diagnose the disorder or would have compelled a reasonable person to seek diagnosis or treatment.

If you have a pre-existing condition, treatment for that condition will be excluded from your Short Term Medical plan.

A pregnancy that exists on the day before your effective date will be considered a pre-existing condition.

**Premium refunds**

If you aren't completely satisfied with your Short Term Medical plan, simply call and cancel coverage within 10 days of delivery and receive a premium refund, no questions asked. The one-time application fee is not refundable.

**State specific exclusions**

Covered charges in excess of reasonable and customary amounts.

**Short Term Medical and Health Care Reform**

Short-term, limited duration plans are not subject to certain provisions of Federal health care reform, including the provisions related to lifetime limits, dependent coverage, preventive care, and pre-existing conditions. The pre-existing condition exclusion for Short Term Medical plans will apply for all insureds, including those under the age of 19.

## Tips and Additional Information

**For more information, or for help applying for coverage, contact your insurance agent.**

Submitting Your Enrollment Form and Payment

Please check that you have:

- answered all questions on the enrollment form
- included necessary signatures
- enclosed your payment

### When Your Coverage Begins

Your coverage will begin at 12:01 a.m. on your approved effective date as long as your enrollment form is complete, meets the requirements for acceptance, and includes the initial premium. Your requested effective date must fall within 45 days of the date you signed the enrollment form.

Upon enrollment, you will receive a welcome kit containing your insurance card and coverage details.

**OR** if you would like to submit your enrollment form directly to Assurant Health you can mail it to:

**Assurant Health**
**P.O. BOX 3175**
**Milwaukee WI 53201-3175**
**800.800.5453**

**OR** Fax your enrollment form to: **414.299.1137**

***About Assurant Health***

Assurant Health has been in business since 1892 and is the brand name for products underwritten and issued by Time Insurance Company, John Alden Life Insurance Company and Union Security Insurance Company. The Assurant Health Web site is AssurantHealth.com.

30217.Fax-GA

| **Requested Effective Date** | | | **Note:** 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. **The agent cannot assign an effective date different than this.** | **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 (Name) (if to be insured) | Birth Date | Name | Birth Date | Name | Birth Date |
|---|---|---|---|---|---|
| 1. | | 2. | | 3. | |

**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.

**Answer the following questions completely and accurately.** **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?
- over 300 pounds if male, or over 250 pounds if female?
- now pregnant, an expectant parent, in the process of adopting a child or undergoing infertility treatment?

**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?
- Emphysema?
- Crohn's disease, ulcerative colitis or hepatitis?
- AIDS or tested positive for HIV?
- stroke?
- kidney disorder, excluding kidney stones?
- diabetes?
- cancer or tumor?
- alcoholism, chemical dependency, drug or alcohol abuse?

| **Deductible Amount** | **Payment Option and Length of Coverage** | **Rate of Payment** | **Total** |
|---|---|---|---|
| ☐ $ 1,000* ☐ $ 2,500 ☐ $ 3,500<br>** Available only with 50% or 80% Rate of Payment* | ☐ Single Payment — Total number of days needed _____<br>☐ Monthly Payment — Coverage is needed for: up to 6 months (30-180 days) | ☐ 100%* ☐ 80% ☐ 50%<br>** Not available with the $1,000 deductible* | |

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

## Electronic Policy Option

| I would like to receive my policy and the company's "Notice of Privacy Practice" via the Internet.....☐ **Yes** ☐ **No**<br>**To receive policy delivery via the Internet, you must provide your email address in the space to the right.** ➡ | Email Address |
|---|---|

## Payment Information

**Step 1: Select a Method of Payment:**

☐ MasterCard ☐ Visa ☐ Check Automatic charge: ☐ Checking ☐ Savings account

*(Only available with the Monthly Payment Option)*

***When submitting via paper application, please submit first month premium via check along with a separate voided check***

Bank Routing Number:_____ Account Number:_____

▼ Enter your Credit Card information here ▼

Card # ☐☐☐☐–☐☐☐☐–☐☐☐☐–☐☐☐☐ Exp. Date: _____ /_____

Authorized Amount $ _____ (Insert Initial Premium Payment Amount)

**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.

**Step 2: Authorization**

- **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 or savings 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.

| **Account Holder's Signature** | **Date** | App Source |
|---|---|---|
| Agent Name<br>Steven McClelland | Agent ID#<br>000508CL000001 | Confirmation Code (home office use only) |

# Fax Cover Sheet

## To: Health Plans of Georgia

## Fax #: 770-271-4012

Please accept my completed application and contact me to confirm receipt.

Name: _____

Email: _____

Phone: _____