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Agent Guide for Health Access



What's New

In this 3/11 version of the guide?

Note: This Agent Guide is updated quarterly. Please refer to the most recent version in the FIND A FORM section of the Assurant Health Sales Agent Information Site (assuranthealthsales.com).

- Page 5 – Information was added to the ABOUT THE AGENT GUIDE section indicating that “Automatic payment” refers to the billing method formerly known as electronic funds transfer (EFT) or Check-o-Matic (COM).
- Page 12 – Information was added regarding EASE Assurant Supplemental Coverage integrated application submissions and paper Assurant Supplemental Coverage integrated submissions.
- Page 12 – The “ten-day period” to review the plan was changed to “ten-day right to examine period.”
- Page 17, 18, 21, 22, 24, 25, and 26 – All references to “electronic funds transfer (EFT)” and “Check-O-Matic (COM)” have been replaced with “automatic payment.”

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Overview of Health Access plans

Health Access Fundamentals plans are fixed-indemnity plans that pay a set amount for certain medical services. This means that they are not major medical insurance plans. Fixed indemnity benefits are provided for hospital confinement and specified medical and surgical events. These benefits are paid in specific amounts for covered events without regard to the costs of services rendered. This plan does not provide expense reimbursement for charges based on the health care provider's bill.

Note: in AZ, DE, GA, LA and SD, this plan must be marketed as supplemental to a major medical plan.

ABOUT THE AGENT GUIDE

*To ensure you are viewing the most updated version of the agent guide, go to the Assurant Health Sales site. Refer to the **Agent Resources** section below for additional information.*

For the purpose of this guide:

- “Application” is one of the following:
 - Paper application
 - Paper enrollment form
 - EASE application submission
- “Applicant” refers to applicant and/or enrollee
- “Policy” refers to policy and/or certificate

- “Automatic payment” refers to the billing method formerly known as electronic funds transfer (EFT) or Check-o-Matic (COM).

This Agent Guide was developed to assist you in marketing our Health Access product. It provides answers to many of your questions and directs you to the proper departments within Assurant Health to find answers that may not be in this guide.

This guide contains new business guidelines and information about plan administration, billing and coverage changes for Health Access Fundamentals. It also contains in force guidelines for Health Access Plans A, B and C. All other information in the guide pertains to Health Access Fundamentals.

This guide does not provide product- or state-specific information.

This information can be found in state variations, underwriting and administrative guidelines and/or the Assurant Health Sales site. Refer to the **Agent Resources** section for additional information.

Not all of our guidelines are specifically stated in this guide. Our practice is to publish only the most common guidelines. If there are specific underwriting questions not answered here, please contact your New Business Service Team. The guidelines listed are merely illustrative of probable action based on our practices and procedures. The Underwriting Department retains the right to deviate from these guidelines based on individual case information.

Assurant Health Sales Site

Access the Assurant Health Sales site at assuranthealthsales.com for information including:

- The most updated version of the Health Access Agent Guide
- State Variations
- Underwriting and Administrative Guidelines
- Product-specific Agent Guides for Assurant Supplemental Coverage (Dental, Accident and Critical Illness/Life)

Manage Your Business with MyBook™

MyBook provides you with quick and convenient online access to member, plan and billing information for in force policies (or policies that have lapsed/terminated). In addition, MyBook keeps you up to date on the status of your business through alert notices. To receive e-mail alerts, make sure your e-mail address is updated periodically in the Assurant Health Sales site. You can easily search for a particular client or sort and view business according to your needs. To learn more about MyBook, view the brief training module located in the Agent Library or through assuranthealthsales.com.

This guide is for agent use only.

LICENSING/APPOINTMENT REQUIREMENTS

Each state's rules and regulations dictate under what circumstances an agent may solicit, and an insurer may accept, business. At a minimum, you must have an active license in the state in which you are writing the application for insurance. Most states also require a company appointment prior to or in conjunction with the solicitation of your first piece of business.

State rules for selling over the Internet (e-commerce) also vary and seem to be evolving. Our practice is to require the soliciting or writing agents to have resident or non-resident licenses and appointments in the resident state of any applicants.

As a licensed agent, you are expected to know the solicitation rules for each state in which you are licensed to sell. If you have any questions regarding resident or non-resident state requirements, please contact License and Contract Support prior to taking your first application.

Assurant Health follows a practice of strict compliance with state rules regarding licensing and appointing agents as it relates to accepting business and paying compensation. Your failure to anticipate these requirements may result in returning applications and the additional need for resolicitation.

Assurant Health only accepts applications that are:

- completed, signed and/or authorized by a currently licensed and appointed agent in the state in which the applicant is a legal resident.
- for a product type that the company has authorized the agent to solicit.
- for a policy form approved by the state in which the applicant is a resident.
- signed and/or authorized by the applicant on or after the effective date of the agent's license/appointment, or after the renewal date. License duration rules vary by state. In applicable states, a copy of a renewed license must be on file with License and Contract Support for us to accept business.
- submitted with a new agent appointment in a state that allows this practice. Call License and Contract Support with questions about specific state requirements. In states where allowed, the Application for Insurance/Enrollment Form and agent appointment should be submitted together and sent to License and Contract Support.

- not altered or corrected with regard to the signature of the proposed insured, the date signed, the city and state or the licensed resident agent's signature.
- actually signed by a licensed and appointed agent; stamped signatures are not acceptable. Applications taken by unlicensed staff, but countersigned by another "licensed" agent are also not acceptable.

General Agents, District Agents/Managers and Managing General Agents are authorized to recruit and nominate writing agents in the states and for the products designated by the Company. They must ensure that every writing agent who solicits insurance for Assurant Health:

- is duly licensed by the state in which he/she solicits; and
- is properly appointed through the Company; and
- is authorized by the Company to submit applications for each type of product.

Submission of business that does not meet these requirements shall be grounds for termination of the General Agent's sales agreement and forfeiture of all rights.

Most states no longer require an appointment for General Agents, District Agents/Managers or Managing General Agents that only receive commission overrides and do not directly engage in selling, soliciting or negotiating insurance. In these states, Assurant Health will not require an appointment unless you notify us that the business activities of your agency require it to be licensed and appointed. This notification must be signed by the principal agent we show on our records and submitted in writing. We suggest you use the Request for General Agency Appointment form at assuranthealthsales.com to notify us. Please check with License and Contract Support if you have a question on the rule for a specific state.

Refer to the Underwriting and Administrative Guidelines, as well as Health Access Fundamentals State Variations, for details about state differences. These documents are located at assuranthealthsales.com.

All application, form and correspondence submissions must be in English.

Eligibility Guidelines

Age Determination

All Assurant Health plans are based on the actual age of the applicant as of the effective date.

- Adults may be written through age 63 (up to age 64).
- Newborns: an application may be written for a newborn as soon as the child has had a two-week well-baby exam. The initial discharge exam following delivery is not adequate.
- Dependents can apply for coverage on a parent's plan through age 25 (up to age 26) if the dependent is not married.*

*Some state variations exist. Refer to state variations at assuranthealthsales.com.

Domestic Partner[†]

A person of the same or opposite gender who resides with the policyholder in a long-term relationship of indefinite duration may apply for coverage. Partners must have an exclusive mutual commitment to be jointly responsible for each other's common welfare, share financial obligations and meet the following requirements:

- At least 18 years of age
- Competent to enter into a contract
- Not be related by blood to a degree that would prohibit legal marriage

[†]Some state variations exist. Refer to state variations at assuranthealthsales.com.

Child-Only Policies

Child-only applications are acceptable for Health Access.

Applications should be submitted with the signature of a custodial parent or legal guardian who has knowledge of the health of the minor dependent and the capacity to legally contract on the child's behalf. Health information should be completed by the custodial parent or legal guardian.

If the parents are divorced but the non-custodial parent wants to buy a plan for the child, the parent

who has custody and knowledge of the child's health history should sign the application to verify the child's health history. The non-custodial parent should sign the application as owner/applicant.

In the case of applications involving more than one child, the youngest child should be listed as the primary insured. Any other children should be listed as dependents. Dependents who are age 18 or older and listed on the application are required to sign the application.

Adding an Applicant to an Existing Pending Application

If a new applicant wants to be considered as part of an existing pending application, the options for consideration are: 1) withdraw the pending application and reapply with all applicants included (the effective date for all applicants will be the same then); or 2) allow the pending application to be issued without the new applicant and reapply to add the new applicant via an in force underwriting application (the applicant being added will have a later effective date).

Non-Eligible Applicants

The following people are not eligible for Health Access plans:

- Disabled individuals
- Expectant parents
- Those in the process of adoption or surrogate pregnancy

Note: non-U.S. citizens are eligible for plans.

Expectant Parents

We will not accept an application for a pregnant female or the father of an unborn child. Coverage for a pregnant mother or the father of an unborn child cannot be applied for until the pregnancy has ended. To be eligible for a plan, the mother must have been released from physician care and the baby must have had a two-week well-baby exam.

Adoption and Surrogate Pregnancy

Applicants currently in the process of adoption or surrogate pregnancy are not eligible for plans.

After the child is placed in the home and has established care with a physician, applicants are eligible to pursue plans through full underwriting.

Other Insurance

Health Access plans can be written if the applicant has medical coverage or another fixed-indemnity plan in force that he or she does not intend to replace. We will not allow a certificate holder to have the following:

- Multiple in force Health Access Fundamentals policies.
- In force Assurant Health HSA plan and a Health Access Fundamentals plan

Workers' Compensation

If an illness or injury is covered by a Workers' Compensation plan, Assurant Health does not provide benefits for that illness or injury. No benefits will be provided by Assurant Health for a work-related injury or illness which would have been covered by the Workers' Compensation carrier if an insured was required by state law to maintain Workers' Compensation insurance, but elected not to do so. Assurant Health will provide benefits for a work-related illness or injury if an insured was not required by state law to carry Workers' Compensation insurance and voluntarily elected not to do so.

Continuity of Coverage

Health Access Fundamentals does not include continuity of coverage in any of the states in which it is currently available. Credit for prior coverage will not be applied against the pre-existing period of the Access Fundamentals plan.

Health Replacement Forms

In certain states, we require a completed Health Replacement Form if the applicant is replacing existing coverage. Refer to the underwriting and administrative guidelines for additional information.

Important Information for You and Your Client

- Health Access plans are not major medical plans and should not be used as substitutes for major medical plans. Please assess your clients' needs carefully before recommending Health Access plans.
- Assurant Health relies on your client's answers to the application questions, and these answers have a significant impact on their eligibility for a plan. Information that is not completely and accurately disclosed may result in plan rescission.
- If your client provided you with any health history information that would require a response of "yes" to a health question, you are required to disclose that information to us.
- Assurant Health does not order medical records for every application. The applicant should disclose his or her full and complete medical information, not assume that medical records will be ordered.
- Obtaining all the required authorizations at the time of application submissions is critical to beginning the underwriting process.
- Clients should contact Assurant Health if they think of any additional information that should be disclosed.

Calculating Rates/Quotes

You can run a Health Access Fundamentals quote on the EASE online system from the Assurant Health Sales site, assuranthealthsales.com.

Rates also can be calculated manually using the Health Access rate sheet located within the Health Access application packet at assuranthealthsales.com under the Health Access category within Find a Form.

A quote or rate sheet must be included with all paper applications. Include the name of the primary applicant on the rate sheet or quote and ensure that it matches the name of the primary insured on the application. For child-only applications, the youngest child should be listed as the primary applicant.

Health Access paper applications that request integrated Dental coverage should include the Dental application and Dental quote/rate sheet.

EFFECTIVE DATE RULES

Effective Date

A space for requested effective date is provided on the application for insurance/enrollment form. The earliest effective date will be determined based on the application signature date:

- If the application signature date is the 1st through the 15th of the month, the earliest effective date is the 1st of the following month.

Example: an application signed on 10/1/10 will have 11/1/10 as the earliest effective date.

- If the application signature date is the 16th through the 31st of the month, the earliest effective date is the 15th of the following month.

Example: an application signed 9/16/10 will have 10/15/10 as the earliest effective date.

- The next 1st or 15th after the initial acceptable effective date determined by the date signed is also acceptable.

Example: an application signed on 10/15/10 will have 11/1/10 as the earliest available effective date, but can have 11/15/10 as the latest effective date.

We will not accept an application with a requested effective date more than 45 days in advance.

Conditional Receipt

Conditional receipt is not available on Access Fundamentals applications.

APPLICATION SUBMISSION

Applications can be submitted via a paper application/enrollment form or online via EASE.

EASE (Electronic Agent Sales Experience)

EASE makes selling and managing your Assurant Health insurance products easier than ever before.

With EASE, you can obtain a quote online and submit your business electronically. Go to the Agent Sales site at assuranthealthsales.com to get started.

You also have the capability to check underwriting status online for all the policies you sell.

For more information about EASE, contact your Sales Manager.

EASE Applications

The demographic applicant information, current insurance information and billing information are collected online.

After this information is completed, several options are available to finish the application submission:

- The application can be completed with the client present and attesting to the health history information.
- The application can be completed without the client present if he or she attests to the health history information online later. Your client will receive an e-mail to attest to the health history information that you submit.
- The applicant can call Assurant Health to complete the Personal Health History Interview (PHHI) by phone. Applicants must call within ten days of the initial application submission from EASE. The agent should prepare the applicant for the interview process.

EASE Integrated Application Submissions

For your convenience, Assurant Supplemental Coverage products (Accident and Dental) can also be added directly to an Assurant Health Access application via EASE. Refer to the Agent Guide for Assurant Supplemental Coverage for more information.

PHHI Applicant Instructions

The following instructions should be provided to the applicant to prepare for the PHHI:

- Your customer should choose one adult applying for coverage who knows the health history of all applicants.
- The customer will speak directly with an Assurant Health underwriter. The interview will last approximately ten minutes.
- Be sure that your client has reviewed any take-away documents presented in EASE.

Interpreters

We will allow interpreters based on the following guidelines:

- An agent cannot act as interpreter.
- A spouse, a child age 12 or older or a family friend may interpret for the family.
- The interpreter should not answer questions for the applicant. The applicant should answer, with the interpretation following.

Paper Applications

The Health Access application/enrollment form must be fully complete for underwriting to begin.

The Health Access application/enrollment forms are state-specific and may be used for the following requests:

- New business applications requesting Access Fundamentals
- Guaranteed/expiry conversions from an existing Health Access Fundamentals plan to a new Health Access Fundamentals plan
- Internal replacements requesting Access Fundamentals
- In force requests for existing Access Fundamental plans

Applications are found on Find a Form (“Health Access” category) on the Assurant Health Sales site.

Paper Integrated Application Submissions

For your convenience, Assurant Supplemental Coverage products (Accident and Dental) can be added directly to an Assurant Health Access application. When submitting a paper integrated application along with Assurant Health Access, please be sure you include an EASE integrated quote along with the completed applications and necessary forms. Refer to the Agent Guide for Assurant Supplemental Coverage for more information.

Fees and Dues

Non-Refundable, One-Time Application Fee

A non-refundable, one-time processing fee will be charged for all applications (varies by state), regardless of application outcome.

Health Advocates Alliance Fee

Access Fundamentals policyholders are charged a \$4 monthly fee for membership in Health Advocates Alliance (varies by state).

PAPER APPLICATION/ENROLLMENT FORM GUIDELINES

Listed below are tips to help you fill out the appropriate information in the key sections of the application/enrollment form, necessary for the underwriting process.

Persons to be Insured

Please refer to the **Eligibility Guidelines** section before filling in this portion of the application.

Make sure to fill in all the following information:

- Date of birth for all persons to be insured (note that Social Security number is not required)
- Complete resident address (address for filing of state income taxes). **P.O. Box is not acceptable.** If any applicant lives outside the resident address, please explain why.
- Telephone numbers so that we may contact the applicant if we need to verify or obtain additional information
- E-mail address

Other Coverage in Force or Applied for

Provide information in regard to any coverage being replaced, coverage in force or coverage applied for. Include the name of the carrier, type of coverage, effective date and termination date. All questions pertaining to other coverage should be answered.

Some states have specific requirements, possibly including a replacement form. Refer to the underwriting and administrative guidelines on the Assurant Health Sales site for additional information.

Requested Effective Date

Complete the requested effective date. Refer to the Effective Date Rules section for further information.

Billing

Select the billing method and provide all required information, including account numbers and signatures. Refer to the **Billing** section for more details.

Health Statement

All questions in the Health Statement section of the application must be answered for each applicant.

A “yes” response to any question will disqualify the applicant from the plan.

If an application is submitted to us with a “yes” response, the application processing fee will be charged even though the applicant will be ineligible for coverage.

Beneficiary for Life Insurance Coverage

Complete the beneficiary election for the primary insured life insurance coverage included in the plan. Availability varies by state. Refer to the Access Fundamentals state variations for information.

Authorizations

Signatures of all proposed insured(s) age 18 or older are required. This includes the signature of the spouse and any dependents 18 or older. Applications for a minor (under age 18) require the signature of a custodial parent or legal guardian.

The parent or legal guardian must have knowledge of the health of the child. The applicant, if someone other than the custodial parent or legal guardian, also must sign the application.

The complete date, time and state signed in are required.

Agent Signature

The licensed agent must properly sign and date the application.

Agent Information

Complete the following information for the writing agent:

- name
- agent number
- contact information, including telephone number, fax number and e-mail address
- agency name and numbers

Type of Activity

Check the appropriate box for a new application or for an in force customer request. If the application is for an in force plan, include the existing plan number and check the requested change.

Application Submission

The application should be submitted immediately after all signatures are completed. If the application is received more than 30 days after the date signed, a new application will be required.

UNDERWRITING PRACTICES

Appropriate risk selection is critical to maintaining stable rates and providing quality benefits. Limited health questions are included on the application. An applicant will be declined if the response to a health question is "yes."

Underwriting Outcomes

The underwriting process will produce one of the following outcomes:

- Issue (accept) – the plan will be sent to you or the applicant.
- Requests for additional information – additional information such as forms, medical records, etc. may be requested. You will receive notification on your EASE status report.
- Counter – underwriting offers to remove an applicant. Counteroffers will be posted on EASE before the plan is issued so you can review the offer with your customer. Any additional delivery requirements must be signed and returned to Assurant Health.
- Decline (reject) – you will receive notification via mail or EASE.

Genetic Disclosure

Assurant Health does not use or collect genetic information for this product. Genetic information includes information related to genetic tests, genetic counseling and any family history of a disease or disorder. If any such information is inadvertently provided by the applicant, it should not be included on any application or communicated to Assurant Health in any manner.

Conditional Issues

When an applicant is removed from the plan due to health history or request, the plan is conditionally issued for completion of the amendment of application.

The policyholder and any applicants 18 years of age and older should sign and return a copy of the amendment to the Underwriting Department. After receipt of the completed form, the plan will be activated. If the amendment is not returned in the required timeframe, the plan will not be activated.

Not Taken Policies

A ten-day right to examine period to review the plan is provided on all plans. Should an applicant decide the plan does not meet his or her needs within this time period, he or she may return the plan and request, in writing or by phone, to have the plan marked NOT TAKEN.

Not taken requests will be granted within ten days of the plan delivery date.

Requests received more than ten days past the plan delivery date will be handled as a request to terminate a plan as of the request date, and any premium refunds will be calculated to that date.

Reissues

Reissue requests are subject to underwriting approval based on our guidelines and practices.

We will consider a request to reissue an in force plan if we receive the request within 30 days of the plan issue date. If we receive a plan change request and the requested date is more than 30 days after the issue date, refer to the **Plan Change Rules** section.

A request to change the effective date of an in force plan is a reissue. A request to change the effective date once the plan has been issued will not be considered if the applicant had no prior coverage. Making this change could result in a change in premium rates. We will not accept requests to backdate the effective plan date.

Medical Records

Since we expect to receive accurate and complete information during the application process, we order medical records for a very limited number of applications received. Ordering records for every applicant would delay the underwriting process and be cost prohibitive.

Note: a signed and dated underwriting authorization form is required to request medical records. If the necessary authorization has not been received with the application, it will be required before records can be requested.

Confidentiality and Release of Information

If the applicant requests the reasons for an adverse decision and the decision was due to confidential information, the following procedures must be followed:

1. The applicant may call, mail and/or fax a written request to the home office, asking that the confidential information be disclosed or sent to the applicant or his or her medical practitioner. Due to HIPAA regulations, if the request is by phone from the primary applicant, we will ask the applicant to verify the following information:
 - Plan/application number
 - Social security number or last 4 digits, if provided with the application
 - Full name of the primary insured or applicant
 - Date of birth of the primary insured or applicant
 - ZIP code
2. If submitting the request in writing, the applicant must sign the request and include the complete name and address of the person to whom the information should be sent.
3. Upon receipt of the request, the Underwriting Department will disclose the information on which the decision was based. To maintain confidentiality, we will not fax or e-mail responses.

LEGAL REQUIREMENTS

Outline of Coverage Requirements

Some states have a legal requirement to provide the state-approved Outline of Coverage to the applicant at the point of sale. Refer to the appropriate state variations to determine if an Outline of Coverage is required.

State-specific Outlines of Coverage define mandates and other differences in coverage specific to those states.

Replacement

Certain states have adopted specific replacement regulations and replacement form requirements that must be followed in the event that another company's insurance plan will be replaced by a fixed-indemnity plan. Refer to the Underwriting and Administrative Guidelines for your state to determine if a replacement form is required for Access Fundamentals applications.

Residence Requirements

Applicants are eligible for health insurance if they are citizens of the United States or are foreign residents living in the United States.

Fair Credit Reporting Act

Federal law requires that a notice be given to any applicant experiencing adverse action. The notice states that a consumer report was reviewed as part of the underwriting process. This would include consumer reports from MIB.

Notification Regarding MIB

MIB, Inc. is a reporting agency that provides insurance carriers with information regarding past reported medical information.

The general rules of MIB, Inc., of which Assurant Health is a member, require that each applicant for insurance be given prenotification regarding MIB and specifically that MIB, Inc., upon request, will supply Assurant Health with information in its files. Assurant Health also may release information to MIB, Inc. This information is part of the application/enrollment form for insurance.

Applicants and/or consumers can request reported information at mib.com or by calling 866.692.6901.

Notice of Insurance Information Practices

To issue an insurance plan, Assurant Health needs to obtain information about the people proposed for insurance. Some of this information will come from the application and some will come from other sources. All information collected by Assurant Health may, in certain circumstances, be disclosed to third parties without the proposed insured's specific authorization. The proposed insured has the right to access and correct collected information that may relate to a claim or civil criminal proceeding. The notice is part of the application/enrollment form for insurance.

HIPAA Privacy

As a business associate of Assurant Health and as a representative working on behalf of each applicant, it is your responsibility to protect the confidential information you collect. Health Insurance Portability and Accountability Act (HIPAA) privacy and security regulations require that you, as a business associate, have physical, administrative and technical safeguards in place to protect this information. Please refer to the Assurant Health privacy plan at assuranthealth.com to understand how protected health information is handled at Assurant Health and how insureds can exercise their individual rights under HIPAA. Please contact the Assurant Health Privacy Office immediately if you are aware of any breach of protected health information.

State Health Insurance Plans

In order to provide plans for people who are unable to purchase satisfactory medical insurance through private insurers, states have enacted state risk pools. For details regarding these types of plans, refer to the underwriting and administrative guidelines at assuranthealthsales.com. Generally, people who have been declined for individual medical plans are eligible to obtain coverage through these plans. Many states also require insurers to notify applicants of their eligibility to apply for coverage under these plans.

People who wish to obtain coverage through a state risk pool plan usually must submit evidence that they have been unable to acquire coverage through private insurers. Assurant Health will assist an applicant in this regard. In order to do so, we require that a fully completed application be submitted to our office. EASE submissions should not be used for this request. Please advise us by separate memo or note, directly on the application form, that the application is being submitted for purposes of qualifying for coverage under a state risk pool plan. Premium should not be collected or submitted with the application, but the processing fee must be included.

If the risk pool is the state's guaranteed issue plan for HIPAA-eligible people, a letter of decline from a private insurer is not required.

BILLING

First Premium

The agent is responsible for collecting the full first premium.* If no premium is submitted, the plan will be considered cash on delivery (COD) and the insured will be billed.

**If automatic payment (formerly Electronic Funds Transfer [EFT] or Check-O-Matic [COM]) or credit card payment mode is requested and all information to process the billing of automatic payment or credit card is received, a check for first premium is not necessary.*

Checks and/or money orders should be made payable to Assurant Health. Checks and/or money orders made payable to an agency will be returned.

Checks submitted with an application should have the same date the application was signed. If we receive a post-dated check, the application will be treated as COD.

Applications can be sent COD, and a bill will be sent with the plan.

In cases where the full premium is not paid at the time of application, a tolerance of 80% of the premium due (not to exceed \$100) will be applied. This means that if the payment falls within this tolerance, the premium will be applied to the plan, the agent's commission will be paid on the total amount due and the balance will be billed to the insured at the next billing cycle.

If no premium or less than the tolerance amount is received with the application, we will mail the insured a bill along with the plan. Policies on automatic payment or credit card will draft as soon as the plan is issued by the Underwriting Department, even if the premium is not due until the following month. In these cases, no commission will be paid until the premium is received.

Payment Modes

- Direct billing (quarterly, semi-annual and annual modes)
- Monthly automatic payments
- Credit card
- List bill

Direct Billing

Quarterly, semi-annual and annual payment modes are direct bill method. Monthly direct billing is not available.

On direct bill plans, premium notices are mailed as early as 35 days prior to the due date and include adjustments for past due premiums, underpayments and overpayments as well as additional charges or credits due to a plan change.

Automatic Payment, (formerly Electronic Funds Transfer or Check-o-Matic) Billing

Automatic payment, (formerly called Electronic Funds Transfer or Check-o-Matic) is a convenient billing method in which premiums are automatically drawn from the payer's checking account. Premiums can be drawn on any day of the month except the 29th, 30th and 31st.

Policies on automatic payment will draft as soon as the plan is issued by the Underwriting Department, even if the premium is not due until the following month.

If automatic payment is requested, be sure to complete the bank draft authorization,* including routing, transit and account numbers. The authorization gives Assurant Health the authority to draft the premium payer's account for premium due. A copy of a voided check is helpful in verifying the appropriate information.

**Authorization types differ depending on the submission type of the application.*

If the above requirements are not met when automatic payment is requested, we will issue on direct bill quarterly mode.

Automatic Payment Draft Date

The automatic payment draft date and the plan effective date should coincide if possible. This ensures that the premium is drafted on the same day of the month that the plan was effective.

Automatic Payment Premium Payments

Even if the applicant's plan is not yet issued, you should encourage the payer to record regular debits from his or her checking account each month. This will help to reduce NSF checks since the first withdrawal will cover all premiums due.

Credit Card

Payment by MasterCard or VISA is available to applicants for **initial premium payment or recurrent premium payments**. Premium to pay the plan to a current date will be charged to the credit card as soon as the plan is activated. For only initial premium payment by credit card, subsequent premiums will be billed by direct bill or automatic payment.

Existing policyholders can make a one-time credit card payment by contacting the Policyholder Service Department. Any premium due will be charged to a credit card rather than being collected by the current billing method.

To set up credit card billing, we require the credit card information and authorization[◊] by the cardholder to draft the account.

Required credit card information includes:

- Card type (VISA or MasterCard)
- Expiration date
- Name of cardholder as it appears on the card
- Signature/authorization of the cardholder
- Cardholder address, if it differs from the policyholder address
- Subsequent billing type and all necessary information if initial payment by credit card is selected

[◊]*The method by which authorization is obtained will differ depending on the submission type of the application.*

List Bill

Refer to the List Bill Agent Administration Guide (Form 29240) for additional information.

List bill enables an employer to payroll deduct premium for individual coverage purchased by employees. Employers do not contribute toward the payment of the individual plans; employees pay 100% of the premiums.

The following are features of the list bill option:

- List bill accounts are billed monthly to the list bill accountholder (employer) on a combined bill.
- Employers select the billing due date, between the 1st and the 28th of the month.
- Employers submit one check that incorporates all employee premiums due.

The employer must complete a list bill agreement form to establish a list bill account. Availability of the list bill option is based on the physical location of the employer.

Billing Mode Changes

Requests to change billing modes following the issue of the plan should be directed to Premium Services, not the Underwriting Department.

PLAN CHANGES

Guaranteed/Expiry Conversion

An eligible person may request a conversion of coverage if he or she is no longer eligible for coverage due to:

- Divorce
- Death of the primary insured
- Dependent who no longer meets eligibility requirements

A spouse or dependent child no longer eligible for coverage may obtain an equal or similar plan without evidence of insurability. Conversions are given a new plan number with continuity of coverage.

A Health Access Fundamentals application is required within 60 days of spouse or dependent status termination. Guidelines for completing the application:

- Complete the demographics information, including name, address, etc.
- Select the billing mode and provide required billing information
- Answers to the health questions on the application are not required
- Applicants age 18 and older must sign the application
- Agent information is required

All required new business forms, such as replacement forms, should be submitted with the application. A quote/proposal is not required.

The plan will be dated with the termination date of the original plan. Assurant will not allow a gap in coverage or an overlap of coverage.

Pre-existing credit will be given based on the amount of time the insured has been on the prior plan.

Benefit amounts accumulated on the prior plan will not transfer to the new plan.

The processing fee will be waived.

A modified commission rate will be paid. If the applicant submits an application for a conversion without agent information included, no agent will receive commission on the conversion plan.

We cannot process add-on dependents with a conversion due to different dating rules. We will process the conversion application first, then an in

force underwriting request can be submitted to consider the addition of the dependent.

If an applicant requests to convert to a plan other than Health Access Fundamentals, an individual medical application and full underwriting will be required. Refer to the Individual Medical Agent Guide for information.

Internal Replacements

An existing Health Access Fundamentals plan cannot be replaced with a new Health Access Fundamentals plan. A 6-month gap is required between the termination date of the existing plan and the requested effective date of the new plan.

If an existing Health Access Fundamentals certificate holder is interested in an Assurant Health Individual Medical plan, refer to the internal replacement guidelines within the Agent Guide.

Note: California, Idaho and Wisconsin differ greatly regarding internal replacement. Please reference the Underwriting and Administrative Guidelines for each state.

In Force Underwriting

In force underwriting handles requests for changes to existing plans that require underwriting. These changes include:

- Addition of spouse, dependents or newborns
- Reinstatements

Addition of Spouse, Dependents or Newborns*

If a newborn is being added to a child-only plan, the newborn must have had a two-week well baby exam prior to applying.

A newborn child or adopted child being added to a parent's in force plan will receive benefits for 31* days from the date of birth or placement for adoption. To continue benefits beyond the first 31 days, Assurant Health must be notified by phone or in writing within 31 days of the newborn's date of birth or the adopted child's date of placement. If the request for benefits is received after more than 31 days, full underwriting will be required.

A Health Access Fundamentals application must be completed and submitted to the In Force Underwriting Department for consideration of coverage.

**Varies by state.*

Requests to add a spouse or dependent require a fully completed Health Access Fundamentals application sent to the In Force Underwriting Department, along with any state required forms. The application/enrollment form will be fully underwritten. Health history will be taken into consideration when assessing the requested change.

Health Access Fundamentals plans have pre-defined benefits. Therefore, there are no changes allowed to the benefits.

SuiteSolutions can be added to an in force plan at any time, and underwriting is not required. Requests to add this optional benefit can be processed with a written request or phone call to the Policyholder Service Desk from either the primary insured or the agent. SuiteSolutions availability varies by state.

Reinstatements

Reinstatement is a request to place a terminated plan back in force with a gap in coverage. The plan cannot be lapsed for more than 6 months.

To reinstate a Health Access Fundamentals plan that has been past due for **less than 31 days**, collection of only one premium on the appropriate premium mode is necessary by mailing or calling the Policyholder Service Desk to have the checking account or credit card drafted.

If the plan is **more than 31 days past due**, but less than 6 months since it has lapsed, the plan may be eligible for reinstatement. Refer to the Reinstatement guidelines within the Agent Guide.

Submissions for In Force Underwriting Requests

Submit a fully completed Health Access Fundamentals application to:

In Force Underwriting
PO Box 551
Milwaukee WI 53201-0551

FAX: 414.299.8811

Note: premiums should not be sent as they do not bind coverage.

What You Can Expect:

- All requests are fully underwritten
- Plans will take effect upon approval from the In Force Underwriting Department and will not be backdated
- We will bill for additional premium if the requested change is approved
- Adding a spouse or dependent does not earn additional commissions

Dependent Guidelines

Under the provisions of each plan, dependents remain eligible for benefits under their original plan:

- as long as they are unmarried
- until age 26
- as long as they are considered disabled; insured dependents will be considered disabled if the dependents cannot engage in any substantial, gainful activity because of their physical or mental condition

Note: these provisions may vary by state.

Covered dependents are eligible to convert to another plan when they no longer meet the eligibility requirements. It is the responsibility of the insured to notify Assurant Health when a dependent no longer qualifies and needs to be removed from the plan.

Address Changes

Follow this procedure for quick and accurate processing of address changes. If calling in an insured's address change, please have the following information ready:

- Insured's name
- Plan number
- Old address
- New address, including ZIP code
- Telephone number
- Temporary or permanent address change

It is important that you remember to list all plans involved in an address change, especially if there is automatic payment or list billing in place.

Note: be especially careful with automatic payment billing where the payer address differs from the insured's address.

A change of address may increase or decrease plan premium. We will send notification to the insured and agent when the address change is made.

State Residency Changes

If an existing customer relocates from one state to another, his or her plan may be affected. Upon notice of the residence change, we will send the customer a notice regarding plan changes. Each situation and state is treated individually, based on the circumstances.

Non-Sufficient Funds (NSF)

A check is submitted twice before it is returned to Assurant Health. If the check does not clear the second time, the insured will be notified by letter than the check was returned and the insured must submit a new check. The insured is given 20 days from the date of the letter to submit the premium. If the plan is on automatic payment, the insured or agent can call the Policyholder Service Department within 20 days to redraw the account. If a replacement check is not submitted or the account is not redrawn, the plan will lapse 30 days from the date of the returned item.

Bank Changes for Automatic Payment

In Writing:

Obtain a new, signed automatic payment authorization and voided check for the new bank account. Allow 30 days' advance notice of all changes to an existing automatic payment account. On a bank change, it is important that the client leave his or her account open for 30 days and one month of premium on deposit for each plan in the old account.

By Phone:

The caller must be the checking account owner or an authorized signatory on the account. If the account routing number begins with a 5 or 9, the account holder must contact the bank to verify the correct routing number for Automated Clearing House (ACH) transactions.

Both:

If we drafted the old account prior to receiving the new account information and the draft is returned unpaid, we will automatically redraw for the premium due at the new bank.

If a draft on a new account is returned unpaid, we generate a letter stating that the premium should be submitted within 20 days or the client should call the Assurant Health Policyholder Service Department to request that the account be redrawn.

Multiple Policies:

If the bank change only affects some plans (i.e., the balance of the plans are continuing to draft from the present bank), list only the plans involved in the change.

Note: refer to the billing section for additional information regarding Multiple Automatic Payments and Employer-Sponsored Business.

Draft Dates

Draft dates can be any date between the 1st and the 28th of the month. Premiums are drafted in the month that they are due.

Balance Due

Additional premium due for a change to an automatic payment plan will be drafted on the next available draft date (1st to the 28th).

Premium Change

Whenever there is a change in the payer's bank information or in the premium amount from the prior draft, the Federal Reserve Board requires that the draft be warehoused for ten days. Assurant Health will send the agent and the premium payer a letter when the draft amount is changed. In these situations, the draft from the premium payer's account will not be processed until approximately ten days from the date of the letter.

Terminations

Requests to terminate a plan should be provided in writing or by phone from the primary insured or agent. Do not stop payment on an automatic payment draft or close an account in an attempt to cancel a plan. Payers other than the primary insured paying the premiums via automatic payment are not authorized to terminate a plan. However, they are authorized to discontinue premium payments from their account. The plan will automatically be placed on direct bill quarterly.

Grace Periods

- 31-day grace period from premium due date
- 20-day grace period from the date a bank draft is returned to Assurant Health.
Contact the Policyholder Service department to redraft the returned premium or send a replacement premium

Plan Changes/Limits/Requirements

POLICY CHANGES	LIMITS/REQUIREMENTS
Guaranteed conversion for dependent	60 days from date of removal from parent's/guardian's plan
Guaranteed conversion due to divorce	60 days from date of divorce
Addition of newborn	31 days from date of birth (see In Force Policy Changes section)
Reinstating after military call-up without evidence of insurability	30 days from discharge or date that extended military coverage ends (63 days for IL)
Return a plan to mark "NOT TAKEN"	10 days from receipt of plan (see Not Taken Plans section)
Terminating with proof of other coverage (backdating a termination date due to other insurance)	30 days limited for backdating. Proof of other coverage must be submitted within 20 days from the date we request proof of other coverage.
To stop a termination	Written notice or phone call must be received at Assurant Health before the termination date specified. If notice is received after the specified termination date, an application/enrollment form is required.

Signature/Form Requirements

POLICY CHANGE REQUIREMENTS	FORMS REQUIRED	SIGNATURE
Addition of newborn	Written notification or phone request	Primary insured (also may be phoned in by agent)
Remove dependent	Written notification or phone request	Primary insured (adult) or agent
Remove spouse	Written notification or phone request	Primary insured or agent
Remove primary insured	Written notification or phone request	Primary insured
Bank/account change/place on automatic payment	Automatic payment authorization form (contact Policyholder Service Department)	Primary insured and payer (if payer is other than the insured)
Automatic payment authorization	Automatic payment authorization form (contact Policyholder Service Department)	Insured and payer (if payer is other than the insured)
Termination (see Terminations section)	Written notification or phone request	Agent and primary insured
Mode change	Written notification or phone request	Agent and primary insured
Address change	Written notification or phone request	Agent and primary insured
Guaranteed conversion requesting same/similar benefits	Manually submitted application with billing section fully completed, signature of eligible conversion applicant if over age 18	Primary insured*
Reinstatements more than 31 days past due (see Reinstatements section)	Application/enrollment form [¥]	Primary insured and/or spouse or dependent if 18 or older*
Reinstatements less than 31 days past due (see Reinstatements section)	Submit appropriate premium due or call Policyholder Service Desk to redraft automatic payment	Primary insured
Addition of spouse and/or dependents	Application/enrollment form [¥]	Primary insured and/or spouse or dependent if 18 or older*

*Additional signatures are required for any dependent 18 years or older and affected by the change.

¥A signed and dated underwriting authorization form is required. Please obtain written authorization from all applicants age 18 years or older and retain the form on file should a request for additional medical information be required.

LAPSES AND TERMINATIONS

Lapses

Plans on direct bill will receive a combination lapse/late payment offer when the premium is ten days past due.

All plans are entitled to a 31-day grace period. The grace period begins the day after the plan due date and ends 31 days after the due date.

Reinstatement

To reinstate a plan that has been past due for **less than 31 days**, collection of only one premium on the appropriate premium mode is necessary by mailing or calling the Policyholder Service department to have the automatic payment redrafted.

If the plan is **more than 31 days past due, but less than six months since it has lapsed**, it is necessary to submit a completed application to our In Force Underwriting department. This form should include all health history questions as indicated on the form, along with the type of request noted. In Force Underwriting will fully underwrite to determine eligibility for reinstatement. Normal underwriting guidelines apply. Any change in health history between the date the plan lapsed and the effective date of the reinstatement will not be eligible for benefits and will be considered during underwriting review.

A reinstated plan will become effective only on or after underwriting approval. Plans will not be backdated.

Premium should not be submitted with the application.

Grace Period vs. Late Payment Offer Period

There is a 31-day grace period offered by the terms of the contract. This means that if a benefit request comes in during these 31 days, it is considered for payment. Assurant Health also provides a late payment offer period. This begins on the tenth day after the due date and continues to the 31st day after the due date. No requests for benefits will be considered after the 31st day.

Terminations

Requests to terminate coverage should be submitted to the Policyholder Service department. A written notification or phone call by the primary insured or

agent is required, and a specific date of termination is necessary.

If a termination request is received in writing and the letter does not indicate a specific termination date, the termination date will be determined by the date of the letter. If the letter was not dated, the termination will be the date the letter was received by Assurant Health.

Backdating Termination Dates

Termination due to other coverage or divorce – we will backdate a plan termination a maximum of 30 days from the date we were notified, provided that proof of other coverage or a divorce decree is received in the Home Office with the request.

Termination due to death or military orders – we will backdate a plan termination date with a death certificate or military orders.

Termination due to eligibility rules - it is the responsibility of the insured to notify Assurant Health when a dependent needs to be removed from his or her plan.

Dependents are considered ineligible when they:

- get married
- reach age 26
- are no longer considered disabled; insured dependents will be considered disabled if the dependents cannot engage in any substantial, gainful activity because of their physical or mental condition

Note: eligibility requirements may vary by state. Refer to state variations for further information.

A spouse or dependent child who is no longer eligible for coverage can obtain a similar plan called a guaranteed conversion without evidence of insurability if an application is submitted within 60 days after that person's plan terminates with us.

Refunds

If the termination date is prior to the paid-to date, a premium refund (minus any balance due amount) will be processed.

IN FORCE GUIDELINES FOR HEALTH ACCESS PLANS A, B AND C

Information in the following sections of the guide applies to Health Access Plans A, B and C, as well as Health Access Fundamentals:

- Agent Resources
- MyBook
- Licensing
- Billing
- Policyholder Service and Administration Guidelines

Other sections of the guide do not apply to Health Access Plans A, B and C.

In force guidelines for Health Access Plans A, B and C do not apply to Access Fundamentals plans.

Note: Health Access Plans A, B and C are no longer available for new business.

In Force Plan Changes

Application Submission

Applications for in force plan changes to Health Access plans A, B and C can be submitted via paper enrollment forms only. These applications are legal entity specific and are often state specific. Applications for Plans A, B and C are not the same applications used for Health Access Fundamentals.

Underwriting Practices

Underwriting is not required for any changes related to a Health Access Plan A. Contact the Policyholder Service Department to submit these requests.

Limited medical questions are included on the Health Access Plan B/C application, and underwriting is required for in force requests.

An applicant's request will be denied if the response to a medical question is "yes."

Plan Changes

Guaranteed/Expiry Conversion

A spouse or dependent child who is no longer eligible for coverage may obtain an equal or similar plan without evidence of insurability. Since Health Access Plans A, B and C are no longer available, conversion will be to Health Access Fundamentals (where available) or to another similar Assurant Health plan. Conversions are given a new plan number with continuity of coverage. A plan-specific Health Access application for Plan B/C is required within 60 days of spouse or dependent status termination.

Note: for Plan A conversions, contact the Policyholder Services department.

In Force Plan Changes

Internal Replacements

If an existing Health Access policyholder is interested in a Health Access Fundamentals plan, the existing plan must have been in force for 12 months. After 12 months, the policyholder can apply for an Access Fundamentals plan. Existing Health Access plans in force for less than 12 months will be considered for replacement with an Access Fundamentals plan if the agent/agency on the existing plan and the new application are the same. A completed Access Fundamentals application and full underwriting will be required.

The effective date of the new plan will be based on the termination of the existing plan. An adjusted commission rate will apply. Continuity of coverage will be applied for the period of time covered under the prior plan.

If an existing Health Access Plan A, B or C policyholder is interested in an Assurant Health Individual Medical plan, refer to the internal replacement guidelines within the Individual Medical Agent Guide.

Reinstatements

To reinstate a Health Access A, B or C plan that has been past due for **less than 31 days**, collection of only one premium on the appropriate premium mode is necessary by mailing or calling the Policyholder Service department to have the automatic payment or credit card redrafted.

If a Health Access Plan A is **more than 31 days past due**, the plan cannot be reinstated.

If a Health Access Plan B or C is **more than 31 days past due**, but less than 6 months since it has lapsed, the plan may be eligible for reinstatement. A completed Health Access Plan B/C application must be submitted to our In Force Underwriting department. This form should include all health history questions completed as indicated on the form, along with the type of request noted. In Force Underwriting will fully underwrite to determine eligibility for reinstatement. Normal underwriting guidelines apply. Any change in health history between the date the plan lapsed and the effective date of the reinstatement will not be eligible for benefits and will be considered during underwriting review.

A reinstated plan will become effective only on or after underwriting approval. Plans will not be backdated.

Premium should not be submitted with the application.

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ASSURANT Health®

Assurant Health
501 West Michigan
Milwaukee, WI 53203

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. Together, these three underwriting companies provide health insurance coverage to people nationwide. Each underwriting company is financially responsible for its own insurance products. Primary products include individual medical, small group, short-term and student health insurance products, as well as non-insurance products and consumer-choice products such as Health Savings Accounts and Health Reimbursement Arrangements. Assurant Health is headquartered in Milwaukee, Wisconsin, with operations offices in Minnesota, Idaho and Florida, as well as sales offices across the country. The Assurant Health Web site is www.assuranthealth.com.

Assurant is a premier provider of specialized insurance products and related services in North America and select worldwide markets. The four key businesses — Assurant Solutions, Assurant Specialty Property, Assurant Health, and Assurant Employee Benefits — partner with clients who are leaders in their industries and have built leadership positions in a number of specialty insurance market segments in the U.S. and select worldwide markets. The Assurant business units provide debt protection administration; credit-related insurance; warranties and service contracts; pre-funded funeral insurance; creditor-placed homeowners insurance; manufactured housing homeowners insurance; individual health and small employer group health insurance; group dental insurance; group disability insurance; and group life insurance.

Assurant, a Fortune 500 company and a member of the S&P 500, is traded on the New York Stock Exchange under the symbol AIZ. Assurant has more than \$26 billion in assets and \$8 billion in annual revenue. Assurant has approximately 14,500 employees worldwide and is headquartered in New York's financial district. www.assurant.com.