**Application Packet**

American Medical Security™

Have you:

- Signed all forms necessary for health insurance application?
- Answered all applicable medical questions?
- Selected a method of payment and enclosed a voided check, if you selected Check-O-Matic?

United Wisconsin Life Insurance Company

# MEMBER APPLICATION TO TAXPAYERS NETWORK INC.

**New/Existing Member Information — Name of Member Paying Dues**

Name: _____ Social Security Number: _____

Business Name (if applicable): _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____ Fax: _____

If existing member, dues paid through: _____

❑ Please enroll me as a member of Taxpayers Network Inc. (If I am not an existing member, the information I've provided will complete my TNI enrollment.)

Tear Here

**➜ Signature Required:**

Taxpayers Network Inc. is a membership association recognized by the IRS as a 501(c)(4) nonprofit organization. Membership dues, contributions or gifts to Taxpayers Network Inc. are not deductible as charitable contributions for federal income tax purposes. Membership dues for Taxpayers Network Inc. are $7 per month ($84 per year). Members receive the educational newsletter Taxpayers Network Quarterly including coupons redeemable for booklets and paperbacks on selected important public issues. Members also receive a valuable package of benefits, discounts and options. Membership dues are subject to change without notice.

Taxpayers Network, Inc. (TNI) agrees to indemnify and defend United Wisconsin Life Insurance Company (UWLIC) Agents/Agencies, their directors, officers, and employees from any and all claims, actions, damages, and other proceedings, together with all costs, including reasonable attorney's fees, arising out of any act, error, or omission by TNI occurring in connection with membership benefits and services, as described in writing in the Member's benefit guide.

Insurance Products
Underwritten by:

UnitedWisconsin Life Insurance Company™
P.O. Box 19032, Green Bay, WI 54307-9032
(920) 661-6020

# Florida Member Application for Group Insurance

Insurance Products
Designed, Administered, and Marketed by:

American Medical Security™
P.O. Box 19032, Green Bay, WI 54307-9032
(920) 661-1111 • (800) 232-5432

❑ New application ❑ Change in Benefits (specify requested date below in Coverage Information)

This application is to be completed by the applicant applying for coverage. For EarlyCare, application is to be completed by the child's parent or legal guardian if child is not of legal age.

Applicant Social Security Number ___ ___ ___ — ___ ___ — ___ ___ ___ ___

Group No. ___ ___ ___ ___ — ___ ___ ___ ___ ___ ___

## Applicant/Person to be covered for EarlyCare

| Last Name | | First Name | | Initial |
|---|---|---|---|---|
| ❑ Single ❑ Married | Address | City | State | ZIP | County |
| Home Phone No. ( ) | Best time to Call | Work Phone No. (if applicable) | Gender ❑ M ❑ F | Date of Birth / / | Height | Weight | Primary Care Physician's Name |
| Applicant Occupation: | | | | | | | |
| Beneficiary Name (for EarlyCare, Payer is automatic beneficiary) | Last | First | Initial | Relationship | | | |
| Premium Payer Name (for EarlyCare if not Applicant) | Last | First | Initial | Home Phone No. ( ) | | | |
| Premium Payer Billing Address (for EarlyCare if not Applicant) | City | State | ZIP | County | | | |

## Dependent Information (If more space is needed, attach an additional sheet of paper, sign and date it.)

| First Name & M.I. (last name if different) | Gender | Date of Birth | Height/Weight | Social Security No. | Primary Care Physician's Name |
|---|---|---|---|---|---|
| Spouse: | ❑ M ❑ F | / / | / | / / | |
| Spouse's Occupation: | | | | | |
| Child: | ❑ M ❑ F | / / | / | / / | |
| Child: | ❑ M ❑ F | / / | / | / / | |
| Child: | ❑ M ❑ F | / / | / | / / | |

Dependents (age 19 and older) attending school full-time, include name of dependent, name/address of school, and number of credits: _____

## Eligibility

❑ Yes ❑ No Are you or any family members covered by Medicare/Medicaid? If yes, list family members and their effective date: _____

❑ Yes ❑ No Are you or any family members pregnant (including spouse not applying for coverage)? _____

❑ Yes ❑ No Are you or any eligible dependent disabled or hospital confined? _____

❑ Yes ❑ No Do any family members intend to keep other insurance coverage in addition to coverage under this policy? If yes, list family members: _____

List the name of the other insurance company(ies) and the policy number(s): _____

❑ Yes ❑ No Are you or any family members currently eligible for or receiving COBRA or State Continuation benefits? If yes, list names, eligibility dates, and date benefits end:

_____

❑ Yes ❑ No Are you a U.S. citizen? If no, list how long in the U.S.: _____ (Attach copy of valid permanent resident card)

## Coverage Information

Medical: ❑ Applicant ❑ Applicant/Family ❑ Applicant/Spouse ❑ Applicant/Child(ren) ❑ Child only

Requested effective date _____ (Effective date may not be guaranteed)

Network Name _____ Product Name _____

Deductible/Copay _____ Coinsurance _____

Upon signature of this application, I am indicating that I have selected the plan design within the Coverage Information section and that I fully understand the benefit levels of this plan.

❑ I am a HIPAA Eligible Individual under Public Law 104-191 as defined in the Prior coverage section on page 3 of this application and I choose to apply for: HIPAA Eligible medical plan selected _____

❑ I am a HIPAA Eligible Individual under Public Law 104-191 as defined in the Prior coverage section on page 3 of this application but I choose to apply for a Non-HIPAA Eligible medical plan selected. I understand there is no guarantee of policy issuance and that the pre-existing condition limitations of the selected plan will apply regardless of my status as a HIPAA Eligible person. _____

## Benefit Options: (Only available with medical coverage)

❑ Yes ❑ No Supplemental Accident Benefit

❑ Yes ❑ No Term Life/AD&D Insurance (If applicable)

❑ Yes ❑ No Dependent Life (If applicable)

❑ Yes ❑ No Optional Term Life and AD&D Insurance Benefit

($10,000 min. - $300,000 max.) Indicate amount: _____

❑ Yes ❑ No Optional Dental Plan

Plan Selected: _____

Prescription Drug: _____

❑ Yes ❑ No ❑ Other _____

## Home Office Use Only

Depending upon state law, this information may be submitted as evidence of insurability.

## MEDICAL HISTORY

A. ❑ Yes ❑ No Have you or any eligible dependent ever been declined, postponed, ridered, rescinded, or rated up for medical, disability, or life insurance with another insurance carrier? If yes, explain: _____

B. ❑ Yes ❑ No In the past five years, have you or any person to be insured received treatment, received therapy, taken medication, or consulted a health care provider for symptoms? If yes, explain: _____

C. ❑ Yes ❑ No Are you or any person to be insured currently taking any prescription medication, over-the counter medication, or vitamin therapy? Please indicate the reason for use: _____

D. ❑ Yes ❑ No In the past five years, have you or any person to be insured been advised to have a test or treatment, been advised to obtain equipment or service or been advised of a condition that may require attention or treatment? If yes, explain: _____

E. ❑ Yes ❑ No Has any person to be insured ever been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? If yes, list names: _____

F. ❑ Yes ❑ No Has anyone to be insured used tobacco products during the previous 12 months? If yes, list names: _____

G. Within the past five years, has any person to be insured been seen by a physician or member of the medical profession or ever had any symptoms that would cause an ordinarily prudent person to seek medical care; had any conditions, diagnosis, consultation, routine follow-up, treatment, therapy, been prescribed any medication, been monitored, or received counseling for any of following?… (Provide details to "Yes" answers below.)

1. Abnormal Test Results ❑ Yes ❑ No
2. Acne ❑ Yes ❑ No
3. Alcoholism/Alcohol Abuse ❑ Yes ❑ No
4. Allergies ❑ Yes ❑ No
5. Arthritis/Pain Disorder ❑ Yes ❑ No
6. Asthma/Respiratory/Sleep Apnea ❑ Yes ❑ No
7. Back/Muscle/Joints ❑ Yes ❑ No
8. Blood Abnormality ❑ Yes ❑ No
9. Bone Disease/Deformity ❑ Yes ❑ No
10. Breast Condition/Implants/Fibrocystic Breast Disease ❑ Yes ❑ No
11. Cancer/Leukemia/Hodgkin's/Lymphoma ❑ Yes ❑ No
12. Cholesterol, elevated ❑ Yes ❑ No
13. Colitis/Spastic Colon/Polyps ❑ Yes ❑ No
14. Congenital Abnormality ❑ Yes ❑ No
15. Cystic Fibrosis ❑ Yes ❑ No
16. Diabetes/Pancreas ❑ Yes ❑ No
17. Digestive System ❑ Yes ❑ No
18. Drug or Substance Addiction/Illicit Use ❑ Yes ❑ No
19. Ear/Throat/Mouth ❑ Yes ❑ No
20. Eating Disorder-Anorexia, Bulimia, Other ❑ Yes ❑ No
21. Emphysema/Lung/COPD/Tuberculosis ❑ Yes ❑ No
22. Endocrine System or Hormonal Disorder ❑ Yes ❑ No
23. Epilepsy/Seizure ❑ Yes ❑ No
24. Eye or Cataracts ❑ Yes ❑ No
25. Esophageal Disorder/ Gastric Reflux ❑ Yes ❑ No
26. Fracture/Dislocation/Internal Fixation ❑ Yes ❑ No
27. Gallbladder ❑ Yes ❑ No
28. Headaches/Migraines ❑ Yes ❑ No
29. Heart/Murmur/Palpitations ❑ Yes ❑ No
30. Heart Valve/Mitral Valve Prolapse ❑ Yes ❑ No
31. Hepatitis/Liver ❑ Yes ❑ No
32. Hernia ❑ Yes ❑ No
33. High Blood Pressure/Hypertension ❑ Yes ❑ No
34. Infertility Testing/Treatment ❑ Yes ❑ No
35. Lupus/Systemic or Discoid ❑ Yes ❑ No
36. Lymphadenopathy/Immune System ❑ Yes ❑ No
37. Menstrual Disorder ❑ Yes ❑ No
38. Mental/Nervous/Psychological ❑ Yes ❑ No
39. Mental Retardation/Down's Syndrome ❑ Yes ❑ No
40. Multiple Sclerosis ❑ Yes ❑ No
41. Muscular Dystrophy/Cerebral Palsy ❑ Yes ❑ No
42. Neurological Disease/Disorder/Impairment ❑ Yes ❑ No
43. Osteoporosis/Osteopenia/Bone-Thinning ❑ Yes ❑ No
44. Ovarian Cysts ❑ Yes ❑ No
45. Pap Smear, abnormal ❑ Yes ❑ No
46. Paralysis ❑ Yes ❑ No
47. Prostate ❑ Yes ❑ No
48. Rectum Colitis/Irritable Bowel/Other Intestinal Disorder ❑ Yes ❑ No
49. Reproductive Organs ❑ Yes ❑ No
50. Sexually Transmitted Diseases (excluding HIV/AIDS) ❑ Yes ❑ No
51. Sinus ❑ Yes ❑ No
52. Skin/Growth/Lesion/Abnormality ❑ Yes ❑ No
53. Spinal Disorder ❑ Yes ❑ No
54. Stroke ❑ Yes ❑ No
55. Systemic Infection ❑ Yes ❑ No
56. Thyroid/Goiter ❑ Yes ❑ No
57. Transplants ❑ Yes ❑ No
58. Tuberculosis ❑ Yes ❑ No
59. Tumors/Growths/Cysts/Fibroids/Lesions ❑ Yes ❑ No
60. Ulcerative Colitis/Crohn's/Regional Ileitis ❑ Yes ❑ No
61. Ulcers-Digestive/Skin/Other ❑ Yes ❑ No
62. Urinary Tract/Bladder/Kidney ❑ Yes ❑ No
63. Uterine Fibroids ❑ Yes ❑ No
64. Vascular Abnormality/Poor Circulation ❑ Yes ❑ No

**Provide details to "YES" answers** (If more space is needed, attach an additional sheet of paper, sign and date it.)

| Question Letter/No. | Name | Illness/Impairment | Dates Treated | Medications/Treatment/Surgery/Physician's Name & Address |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

## Prior Coverage

### Prior Coverage Information for HIPAA Guaranteed Issue Plans

Do you meet the requirements of a Federally Eligible Individual under HIPAA legislation (P.L. 104-191)?

Please indicate yes or no or N/A to the following:

❑ Yes ❑ No 1. Have you or your dependents had a total of 18 or more months of prior creditable health coverage, the most recent being an employer sponsored plan?

❑ Yes ❑ No ❑ N/A 2. Are you or your dependents ineligible for coverage under a group plan, Medicare Part A or B, or Medicaid, and do not have any health coverage now in force?

❑ Yes ❑ No ❑ N/A 3. Was your or your dependents most recent employer sponsored health insurance plan coverage terminated for reasons other than fraud, nonpayment of premiums on your behalf, or intentional misrepresentation of material fact?

❑ Yes ❑ No ❑ N/A 4. If offered to you and your dependents, did you elect to continue your prior employer sponsored insurance plan coverage under COBRA or a similar state continuation law?

❑ Yes ❑ No ❑ N/A 5. If you or your dependents elected COBRA or state continuation, has that coverage, or will it soon be, exhausted?

❑ Yes ❑ No ❑ N/A 6. Have you or your dependents had less than a 63-day break in coverage from the most recent employer sponsored plan?

If you answered No to ANY of the above questions, the pre-existing condition limitation MAY apply to you and any dependents. If you answered Yes to ALL of the above requirements you or your dependents qualify as a HIPAA eligible person; as a result: 1) we MAY waive the pre-existing condition limitation for you and your dependents as allowed by state law, and we will advise you accordingly; or 2) you or your dependents may qualify for a state-sponsored plan. If (2) applies in your or your dependents state, we will advise you or your dependents on how to enroll in the state plan. IF YOU ANSWERED YES TO ALL OF THE ABOVE REQUIREMENTS PLEASE ATTACH A CERTIFICATE OF CREDITABLE COVERAGE FROM THE PRIOR PLAN, OR ANY OTHER DOCUMENTS TO PROVE THAT YOU OR YOUR DEPENDENTS HAD PRIOR COVERAGE.

❑ Yes ❑ No 7. Are you or your dependents buying this insurance to replace prior group health coverage? If no, the pre-existing condition limitation will apply. If yes, according to state law: 1) we may waive the pre-existing condition limitation for you and any dependents; or 2) you may qualify for a state-sponsored plan. If 2) applies in your state, we will advise you on how to enroll in the state plan. If yes, you must also attach a Certificate of Creditable Coverage from the prior plan and complete all of the following:

Prior employer sponsored coverage effective date:_____

Prior employer sponsored coverage termination date:_____ Reason for prior coverage termination: _____

Who was covered?_____

Prior coverage was provided by: ❑ your employer sponsored plan ❑ spouse's employer sponsored plan

Give name of prior insurance company, policy/certificate number, address, and phone number: _____

_____

_____

❑ Yes ❑ No 8. If prior coverage was in effect for less than 18 months, did you or your dependents have any preceding health coverage?

If yes, was the coverage provided by:

❑ your employer group plan ❑ spouse's employer group plan ❑ individual policy you purchased for yourself ❑ other: _____

Give name of insurance company and policy/certificate number: _____

Who was covered?_____

## Terms and Conditions of Insurance

The Applicant shall furnish to the Insurer any information required for the Insurer to administer the Insurance. The Applicant shall have records available for the Insurer to inspect at any time while insurance is in force, and for up to the earlier of three years after termination date, or final adjustment and settlement of claims is made. The Insurer reserves the right to waive or change any of the above requirements at any time.

INSURER UNDERWRITING REQUIREMENTS

The Applicant is required to submit an Application for Insurance for self and/or for all eligible Dependents to be insured. Insurance for any person is not effective until the date specified by the Insurer. Depending upon the law, the Insurer may have the right to decline the Application for any person for whom information has been submitted in the Application. We will waive the pre-existing limitation for conditions disclosed on this application, but we may place an exclusion rider on certain condition(s).

TERMINATION OF INSURANCE

You may terminate insurance at any time by providing us written notice prior to the requested termination date. The termination date will be the first of the month. Insurance will terminate at 12:01 A.M. central standard time on the termination date. The Insurer will terminate insurance if the Applicant fails to pay premium on the due date, except that coverage continues for a grace period of 31 days after the premium due date. If before any premium due date the Applicant provides advance written notice to the Insurer of request to cancel, then the grace period coverage does not apply. In addition to reasons for termination that are specified in the group insurance Policy, the Insurer may also reform or rescind for fraud or material misrepresentation. The Insurer will provide the Applicant with a minimum of 45 days advance written notice of termination date (unless due to nonpayment of premium, fraud or misrepresentation). Termination will not prejudice a valid claim existing on the termination date, unless due to nonpayment of premium, fraud or misrepresentation.
Upon termination, Applicant may request reinstatement of coverage by paying all applicable premium, plus a nonrefundable reinstatement fee when allowed by state law. Insurer will deposit payment during review of Applicant's request. Depositing Applicant's check does not mean acceptance and does not guarantee reinstatement. Insurer can approve or decline reinstatement request and will notify Applicant in writing.

## To be a valid application, your signature and the date you sign it are required.
## Signature Required-Applicant Agreement

I understand that the above answers will be relied upon by United Wisconsin Life Insurance Company (the Insurer) in the issuance of a certificate of insurance. I declare all statements contained in this entire form about me and my dependents to be insured are true and correct to the best of my knowledge and that no material information has been withheld or omitted. I understand and agree that the Insurer is not bound by any statement made by or to any agent unless written herein. **I agree that no insurance will be effective until the date specified by the Insurer in the certificate of insurance. The actual effective date may not be the requested effective date.**

To assist with determining my creditable coverage, I authorize any insurance company, third-party administrator, or other carrier or provider of health benefits to release to the third-party administrator for Insurer certificates of creditable coverage and all such information.

State law may require a group health plan to follow rules for use of medical history, rating, renewability, and replacement of prior coverage when the plan is issued to a self-employed individual, a sole proprietor, an independent contractor, a partner, or a sole employee of a Subchapter S or Chapter C Corporation. If such law applies to my state of residence, the agent has advised me about the law and I hereby certify that I do not qualify for such group health plan.

**Any person who knowingly and with intent to injure, defraud, or deceive 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. Information on this application is valid for a maximum of 60 days from date of signature.**

- I also hereby acknowledge receipt of the "Protecting Your Privacy" and "Protecting Your Health Information" notices. I understand that I may request an additional copy of these notices at any time.
- I understand this policy will not pay benefits during the first 12 months after the effective date for a disease or physical condition I now have or have had in the past that has not been disclosed on this application.

Applicant Signature X _____ Date _____
(If applicant for EarlyCare is not of legal age, signature must be the child's parent or legal guardian.)

If signed by a representative of applicant, please indicate the representative's authority to act on behalf of applicant. _____

Spouse Signature X _____ Date _____
(If spouse is to be insured)

Regional Office _____

Agent Name _____

Address _____

Phone ( ) _____ Fax ( ) _____ Identification Number _____

**I certify that I delivered the "Protecting Your Privacy" and the "Protecting Your Health Information" notices to this applicant, as required by law.**

Licensed Agent Signature X _____

## Signature Required/Authorization To Release Medical Information For Underwriting

Please clearly print all information.

I hereby authorize those physicians, medical practitioners, hospitals, clinics, veterans administration facilities, medical information services, urgent care facilities, and other medical or medically related entities, insurance or reinsurance companies, and consumer reporting agencies that have information available as to the present or former physical health condition, including drug or alcohol or domestic abuse, and/or treatment of me or my dependents to release any and all such information, including, but not limited to, medical records, health-care provider notes, laboratory tests and results, diagnoses, treatment, and prognoses. I understand the information obtained by use of this authorization may be used to determine eligibility for issuance of health coverage and eligibility for benefits under an existing policy/certificate of insurance for me and my dependents. This authorization is not applicable to psychotherapy notes.

I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall expire 15 months after the termination of any coverage I obtain. I understand that I may request a copy of this authorization. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on my authorization. Because this authorization is given as a condition of obtaining insurance coverage, my revocation will not prevent the Insurer from the right to contest a claim under the policy if another law so allows. Should me or my dependents refuse to sign this authorization, I understand it may affect my enrollment in the benefit plan. All pages must be attached and complete, including this authorization for the application to be considered complete. Incomplete applications may be rejected.

Customer Signature X _____ Date _____
(For EarlyCare, signature must be the child's parent or legal guardian if customer is not of legal age.)

If signed by a representative of applicant, please indicate the representative's authority to act on behalf of applicant.

_____

Spouse Signature X _____ Date _____
(If spouse is covered)

Signature of Each Covered Dependent Age 18 and over:

X _____ Date _____ X _____ Date _____

X _____ Date _____ X _____ Date _____

# FLORIDA
# Disclaimer Statement

PLEASE COMPLETE EITHER PART I, PART II, OR PART III WHICHEVER IS APPLICABLE.

The State of Florida enacted legislation governing small employer group health plans to promote the availability of health insurance coverage to small employers regardless of their claims experience or their health status. This legislation applies to all small employers with 1 to 50 employees.

PART I: *No portion paid by employer*

❑ I UNDERSTAND that I am applying for a health care coverage plan that is not a small employer group health plan and that no portion of my premium payment shall be paid for by my employer. Further, my employer does not participate in the collection or distribution of premiums or facilitate the administration of the health care coverage in any manner.

PART II: *Employer-paid coverage exempted from small group reform*

I UNDERSTAND that I am applying for a health care coverage plan that is not a small employer group health plan. A portion of my premium payment is paid by my employer on my or my spouse's (if applicable) behalf based on the following condition:

❑ I am a part-time employee working fewer than 25 hours per week and am not eligible for a small employer group health plan.

❑ I am a temporary or substitute employee and am not eligible for a small employer group health plan.

❑ I am a self-employed individual or a sole proprietor and elect to purchase a health care coverage plan that is not a small employer group health plan. I knowingly and voluntarily disclaim the option of choosing a small employer group health plan.

PART III:

❑ I am not employed.

Any person who knowingly and with intent to injure, defraud, or deceive 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.

_____ _____

Applicant's Name (printed) and Signature Date

_____

Applicant's Social Security Number

_____ _____

Spouse's Signature (if applicable) Date

_____ _____

Writing Agent's Name (printed) and Signature Date

_____

Agent Florida License Number

Insurance Products

Designed, Administered, and Marketed by:

American Medical Security™

P.O. Box 19032, Green Bay, WI 54307-9032
(920) 661-1111 • (800) 232-5432

Underwritten by:

UnitedWisconsin Life Insurance Company™

P.O. Box 19032, Green Bay, WI 54307-9032
(920) 661-6020

# METHOD OF PAYMENT

**Please Select the Method of Payment**

❑ Monthly Check-O-Matic ❑ Credit Card ❑ Monthly Direct Bill (if available) ❑ Quarterly Direct Bill

**Credit Card Authorization — Please Print Clearly (Not available in Ala., Ga., or Kan.)**

❑ VISA ❑ MasterCard ❑ Discover

I authorize American Medical Security, Inc. (AMS) to bill my credit card account for the total amount due. This authority is to remain effective until I provide AMS with written notification of cancellation. I understand that adequate time will be needed to implement any action.

Applicant Name: _____

Cardholder Name: _____

Credit Card Number: _____ Expiration Date: _____

City: _____ State: _____

Phone: _____

**➜ Signature of Cardholder:**

Tear Here

**Check-O-Matic Authorization**

Applicant Name: _____ Group Number: _____

Payer Name: _____ Relationship to Applicant: _____

Name of Depositor: _____
Print exact name as it appears on financial institution records.

Address: _____

Phone: _____

I (we) hereby authorize American Medical Security, Inc. to initiate debit entries to my (our) checking account and the Financial Institution named below to debit the same to such account. American Medical Security, Inc. will not be held responsible for a policy lapse or cancellation due to nonpayment if the withdrawal is presented and not honored for any reason and the amount due is not paid.

Attach a voided check here

Financial Institution Name: _____ Branch: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____

This authority is to remain effective until I (we) provide AMS and the financial institution with written notification of cancellation. I (we) understand that adequate time will be needed to implement any action.

Names: _____

**➜ Signature:** **Date:**

If the VISA/MasterCard/Discover request for payment is declined, or the Check-O-Matic or direct payment by check transactions is returned for non-sufficient funds, a $25 nonrefundable service fee will be applied when allowed by state law. All total costs will be withdrawn the first of the month.

## Additional Information

American Medical Security™

- Optional Forms (Signature Required)
  - Authorization to Disclose Medical Information for Customer Service
  - Consent to Release Medical Information
- Notifications
  - Protecting Your Privacy
  - Protecting Your Health Information
  - Important Notices to Persons on Medicare
  - Federal Women's Health and Cancer Rights Act of 1998

United Wisconsin Life Insurance Company

# Protecting Your Privacy

American Medical Security Group, Inc. (AMS)* strives to protect the personal financial information of current and former customers.

We want you to know that the information you provide is safe and used responsibly. To maintain the level of service you expect from AMS, we may need to share limited personal financial information within our family of companies and with selected business partners.

*You can be certain that protection of your personal financial information is one of our priorities.*

### *Safeguards in Place at AMS*

We use data encryption and storage technology that protect your sensitive personal information. At AMS, we have administrative, technical, and physical safeguards in place to ensure privacy. These include:

- Policies and procedures for handling information.
- Limited access to facilities where information is stored.
- Requirements for third parties to contractually comply with privacy laws.
- Continuous review of company security practices.

We provide training on confidentiality and customer privacy to ensure employees are dedicated to keeping your personal information safe and secure.

### *Your Protection on the Internet*

We collect limited data from our Internet site, such as the date, time, and areas of our site that are visited. This general information helps us improve our site and makes it easier and more convenient for you to use.

If we ask for personal information on the Web site, you will enter a "secure" mode. The following security features keep your information safe:

- A secure server using 128-bit encryption and authentication technologies, verified by Verisign, Inc. (a leading provider of secure, online certificates).
- Site design to limit display of customer information to only what is necessary.
- Specific user names and passwords to protect sensitive information.

### *Types of Information We Gather and Use*

In administering health benefit plans, we gather and maintain information that may include nonpublic personal information:

- From applications, supporting documents, and other forms (for example, phone/Social Security/account numbers, income, and employment history).
- About your transactions with us or our affiliates (for example, payment history and other account information).
- From business partners, vendors, and service companies (for example, payment processing center or credit union).
- From health-care providers, insurance companies, and third-party administrators (for example, medical records, claim payment information).

At times, we need to disclose your nonpublic, personal information to our business partners as necessary to affect, administer, or enforce our transactions with you. We may also share all of this information with companies that perform services on our behalf, provided they contractually agree to keep the information confidential.

### *In Certain States, You May Be Able to Access and Correct Personal Information*

You may have the right to access and correct personal information we have collected about you. Personal information includes information that can identify you (e.g., your name, address, Social Security number, etc.).

### *Our Commitment to You*

You're a valued customer, and the information you provide to us is safe and used responsibly. We'll continue to maintain your privacy and provide you with information about how we share your nonpublic personal financial information.

If you have questions about our privacy guidelines, please call us toll-free at (800) 232-5432, Ext. 15201, or visit the Web site at www.eAMS.com and click on Privacy Policy. Customer service representatives are available 24 hours a day, 365 days a year.

*For purposes of this notice AMS includes, among other entities, third-party administrators American Medical Security, Inc., AMS Benefit Administrators and Insurance Services, Health Plan Administrators, Inc., and Carolina Benefit Administrators, Inc.; and insurer United Wisconsin Life Insurance Company.

NO-0461-00-H-00 5/02

# Protecting Your Health Information

***THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.***

American Medical Security Group, Inc., its affiliates and subsidiaries, collectively AMS*, responsibly use your individually identifiable health information (referred to as "confidential information"). Confidential information includes information that is created or received by a health-care provider, health plan, employer, or health-care clearinghouse. It also includes information related to your past, present, or future physical/mental health and payment for the provision of your health care.

*AMS may use and/or disclose your confidential information without your authorization for the following purposes:*

- Rating and other activities relating to the placement or renewal of health benefits.
- Billing, claims payment, review of health-care services, and the management of health-care and related services by health-care providers.
- Providing appointment reminders or information about treatment alternatives, other health-related benefits, and services.
- Providing information for treatment (coordination and management of health-care related services), payment, or health-care operations.

We may also use and/or disclose your confidential information without your authorization as permitted or required by law (e.g., public health authority or Food and Drug Administration matters; public health intervention or investigation purposes; evaluation relating to the medical surveillance of the work place; work-related illnesses or injuries; civil, administrative, or criminal investigations and/or inspections; judicial and administrative proceedings; local, state, and federal law enforcement purposes). We may also use it for disclosures to the sponsor of a group's health plan, health insurance issuer, or HMO.

Your authorization is required for AMS to use your confidential information to determine eligibility for enrollment and continued eligibility under your health plan. An authorization must also be submitted if you choose to appoint individuals, other than those allowed by law, to receive information about you. You may revoke the authorization in writing at any time unless we are acting or have acted in reliance on an existing authorization from you.

*You have the right to:*

- Request an alternate address or other method of contact if you believe that sending your confidential information to its original location may endanger you.
- Inspect and copy your confidential information.
- Request restriction on certain uses or disclosures; however, these restrictions are subject to agreement by AMS.
- Receive an accounting of the disclosures we make involving your confidential information.
- Amend your confidential information (in limited situations).

AMS will maintain the privacy of confidential information as required by law and by the notice currently in effect. AMS is also required to provide this notice of our legal duties and privacy practices related to protected health information. This notice is effective April 1, 2003. We reserve the right to make changes or revisions to the terms of this notice and will send you a new notice if any material changes are made.

If you believe your rights have been violated, you may contact AMS or the secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint. You may send information to AMS at the address listed below:

American Medical Security, Inc.
Attn: Customer Service Department/Privacy Officer
P.O. Box 19032
Green Bay, WI 54307-9032

If you wish to contact the Department of Health and Human Services, please call us and we'll provide you with the appropriate address.

You have the right to receive another paper or electronic copy of this notice. To request another copy or to get more information, you may call AMS at:

**(800) 232-5432, Ext. 15201**

Or visit the Web site at:

**www.eAMS.com**

Customer service representatives are available to assist you 24 hours a day, 365 days a year.

*For purposes of this notice AMS includes, among other entities, third-party administrators American Medical Security, Inc., AMS Benefit Administrators and Insurance Services, Health Plan Administrators, Inc., and Carolina Benefit Administrators, Inc.; and insurer United Wisconsin Life Insurance Company.

NO-0459-00-H-00 4/03

# Consent to Release Medical Information

*Optional Consent — You are not required to sign.*

Please clearly print all information.

This Consent will permit any physician, medical practitioner, hospital, clinic, Veterans Health Administration facility, insurance/ reinsurance company, or other appropriate entity having information about the onset or cause, diagnosis, treatment, prognosis related to any physical or mental condition including drug or alcohol abuse, communicable disease, accident, or injury of you or your minor children, as indicated below, to release to American Medical Security, Inc. or its legal representatives any and all such information. The information you consent to release may include confidential information or a personal medical history for you or your minor children. This information will be used solely for the determination of benefits on the claim and will be held in strict confidence.

As required by state regulations, we need to inform you that the information you authorize for release may include documentation regarding the presence of a communicable disease or venereal disease. This information may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, human immunodeficiency virus (HIV), and acquired immune deficiency syndrome (AIDS).

If the documentation received includes information regarding domestic abuse/violence, we cannot use this as a basis for denying, refusing to issue, or canceling your insurance coverage. Nor can this information be used as a basis to restrict or exclude coverage or benefits under your plan. We want to assure you that we are in no way indicating that your records will include this type of information.

You may revoke this Consent at any time upon your written request. It will expire automatically following six months from the date of signature below, except in North Carolina and Wisconsin. In North Carolina this Consent is valid for the term of the policy. In Wisconsin this Consent is valid for the term of the policy or while the claim(s) is pending, whichever is longer. A copy of this document shall be as valid and effective as the original and is available upon request at any time.

The nature of the information consented to be disclosed may include, but is not limited to, the following:

| | | | | |
|---|---|---|---|---|
| Anesthesia Notes | History and Physical | Pharmacy Records | Consult Report | Hospital Records |
| Physicians' Orders | Dental Records | Medical Records | Progress Notes | Drug/Alcohol/Substance |
| Nurses' Notes | Therapy Records | Abuse Records | Operative Report | Police/Accident Report |
| Discharge Summary | Pathology/Lab Reports | | | |

If you or any of your dependents have used another name (for example, maiden name, stepchild, etc.), please write the name(s) here:

_____

➜ **Customer Signature:** _____ **Customer Social Security Number:** _____ **Date:**_____

*For EarlyCare, the signature must be the child's parent or legal guardian if the customer is not of legal age.*

➜ **Spouse Signature:** _____ **Date:**_____

*If spouse is covered.*

If signed by a representative of the customer, please indicate the representative's authority to act on behalf of the customer.

_____

Signature of each insured dependent age 18 and over:

➜ **Dependent Signature:** _____ **Date:**_____

➜ **Dependent Signature:** _____ **Date:**_____

➜ **Dependent Signature:** _____ **Date:**_____

➜ **Dependent Signature:** _____ **Date:**_____

For copies of this Consent form, visit www.eAMS.com and click on Privacy Policy or call (800) 232-5432, Ext. 15201.

For office use only.

_____

Group Number Certificate Number

# Authorization to Disclose Medical information for Customer Service

## *Optional Authorization — You are not required to sign.*

Please clearly print all information.

For the purpose(s) of customer service and related activities, I hereby agree, on my behalf and on behalf of my minor dependents, that information available regarding coverage or any claim regarding me or my minor dependents may be released by American Medical Security Group, Inc. (AMS)* to me, my spouse, my parents (for dependents age 18 or over), my medical providers, my plan sponsors/employers, my agent(s) of record, as applicable, or as may be otherwise lawfully permitted, or as I may further authorize in the box below.

## *Optional Additional Authorized Individuals*

I additionally authorize the following individual(s) to receive the above-named information.

Full Name: _____ Relationship to Customer: _____

Full Name: _____ Relationship to Customer: _____

Please Note: An Authorization is not needed for disclosures related to my or my minor dependents' treatment, the payment for such treatment, or related health-care operations as defined under 45 CFR parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information. I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the authorized recipient and may no longer be protected by state or federal law. This Authorization does not apply to psychotherapy notes.

I agree that a photographic copy of this Authorization shall be as valid as the original and that this Authorization shall expire 15 months after the termination of any coverage I obtain (In Georgia and Texas, 24 months from the signature date). I understand that I may request a copy of this Authorization. I understand that I may revoke this Authorization at any time in writing unless action has been taken in reliance on my Authorization. I understand that I may refuse to sign this Authorization. If I choose to sign this Authorization, I understand that I have the right to request access to my protected health information that may be used or disclosed.

## *Information Needed To Identify Your Plan*

Primary Customer Social Security Number: _____

Primary Customer Name Printed Clearly: _____

➜ **Customer Signature:** _____ **Date:** _____
*For EarlyCare, the signature must be the child's parent or legal guardian if the customer is not of legal age.*

➜ **Spouse Signature:** _____ **Date:** _____
*If spouse is covered.*

➜ **Legal Representative Signature:** _____ **Authority:** _____ **Date:** _____
*If signed by a legal representative of the customer, please indicate the legal representative's authority to act on behalf of the customer.*

Signature of each covered dependent age 18 and over:

➜ **Dependent Signature:** _____ **Date:** _____

➜ **Dependent Signature:** _____ **Date:** _____

➜ **Dependent Signature:** _____ **Date:** _____

➜ **Dependent Signature:** _____ **Date:** _____

For copies of this Authorization, visit www.eAMS.com and click on Privacy Policy or call (800) 232-5432, Ext. 15201. You may fax Authorizations to (920) 661-4415 or mail them to American Medical Security, Inc., Attn: Imaging Department, P.O. Box 19032, Green Bay, WI 54307-9032.

For office use only.

_____

Group Number Certificate Number

*AMS includes a third-party administrator, American Medical Security, Inc.; an insurer, United Wisconsin Life Insurance Company; and their affiliates. It also includes a contracted and nonaffiliated entity, Carolina Benefit Administrators, Inc.

# Important Notice to Persons on Medicare

*This insurance duplicates some Medicare benefits. This is not Medicare Supplement Insurance.*

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the Policy. It also pays a fixed amount, regardless of your expenses, if you meet other Policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

*This insurance duplicates Medicare benefits when:*

- Any expenses or services covered by the Policy are also covered by Medicare; or
- It pays the fixed dollar amount stated in the Policy and Medicare covers the same event.

Medicare generally pays for most or all of these expenses.

*Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:*

- Hospitalization.
- Physician services.
- Hospice care.
- Other approved items and services.

*Before you buy this insurance:*

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

GN-1006-00-1-00 4/02

---

# Federal Women's Health and Cancer Rights Act of 1998

The federal Women's Health and Cancer Rights Act of 1998 requires that benefits must be provided for:

- Reconstruction of a surgically removed breast;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment for physical complications from all stages of mastectomy, including lymphedemas.

These benefits are subject to applicable terms and conditions under your health plan, including copayments, deductible, and coinsurance provisions. They are also subject to medical insurance limitations and exclusions.

This notification is a requirement of the act. If you have any questions, our customer service representatives are ready to assist you 24 hours a day, 365 days a year at (800) 232-5432.

American Medical Security, Inc. is a third-party administrator for self-funded plans and for United Wisconsin Life Insurance Company, and other insurers.

GN-2426-00-1-00 4/02

IP-0001-00-1-00 4/03

Insurance Products

Designed, Administered, and Marketed by:

American Medical Security™

P.O. Box 19032, Green Bay, WI 54307-9032
(920) 661-1111 • (800) 232-5432

Underwritten by:

UnitedWisconsin Life Insurance Company™

P.O. Box 19032, Green Bay, WI 54307-9032
(920) 661-6020

AF-0094-12-1-00 4/03