

SERFF Tracking Number: AMCM-126120101 State: Arkansas  
 Filing Company: American Community Mutual Insurance Company State Tracking Number: 42213  
 Company Tracking Number: AR HA-1 5/09  
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)  
 Product Name: Individual Application  
 Project Name/Number: /

## Filing at a Glance

Company: American Community Mutual Insurance Company  
 Product Name: Individual Application SERFF Tr Num: AMCM-126120101 State: ArkansasLH  
 TOI: H16I Individual Health - Major Medical SERFF Status: Closed State Tr Num: 42213  
 Sub-TOI: H16I.005A Individual - Preferred Provider (PPO) Co Tr Num: AR HA-1 5/09 State Status: Approved-Closed  
 Filing Type: Form Co Status: Reviewer(s): Rosalind Minor  
 Author: Michele Sapikowski Disposition Date: 05/01/2009  
 Date Submitted: 04/22/2009 Disposition Status: Approved-Closed  
 Implementation Date Requested: On Approval Implementation Date:  
 State Filing Description:

## General Information

Project Name: Status of Filing in Domicile:  
 Project Number: Date Approved in Domicile:  
 Requested Filing Mode: Review & Approval Domicile Status Comments: Exempt from filing in the state of Michigan  
 Explanation for Combination/Other: Market Type: Individual  
 Submission Type: New Submission Group Market Size:  
 Overall Rate Impact: Group Market Type:  
 Filing Status Changed: 05/01/2009 Explanation for Other Group Market Type:  
 State Status Changed: 05/01/2009  
 Deemer Date: Corresponding Filing Tracking Number:  
 Filing Description:

Enclosed for review and approval is form AR HA-1 5/09 Arkansas Application for Individual Health Insurance Policies. This is an individual health insurance application that will be used to market all individual health insurance policies currently being marketed in your state.

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These forms are exempt from filing in our domiciliary state of Michigan. Any bracketed material represents variable information. No such items will be contradictory to any applicable state or federal law.

This is a new form and does not replace any forms currently in use.

## Company and Contact

### Filing Contact Information

Patricia Robbins, Sr. Compliance Specialist probbins@american-community.com  
 39201 Seven Mile Road (734) 591-4708 [Phone]  
 Livonia, MI 48152 (734) 591-4628[FAX]

### Filing Company Information

American Community Mutual Insurance Company	CoCode: 60305	State of Domicile: Michigan
39201 Seven Mile Road	Group Code:	Company Type:
Livonia, MI 48152	Group Name:	State ID Number:
(800) 991-2642 ext. [Phone]	FEIN Number: 38-1290976	
	-----	

## Filing Fees

Fee Required?	Yes
Fee Amount:	\$20.00
Retaliatory?	No
Fee Explanation:	1 application form = \$20.00

Per Company: No  
 ACMIC USE ONLY acct # 6200030

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Community Mutual Insurance Company	\$20.00	04/22/2009	27335384

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/01/2009	05/01/2009

### Amendments

Item	Schedule	Created By	Created On	Date Submitted
Individual Application	Form	Pat Robbins	04/23/2009	04/23/2009

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(PPO)  
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## Disposition

Disposition Date: 05/01/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AMCM-126120101 State: Arkansas  
 Filing Company: American Community Mutual Insurance State Tracking Number: 42213  
 Company  
 Company Tracking Number: AR HA-1 5/09  
 TOI: H161 Individual Health - Major Medical Sub-TOI: H161.005A Individual - Preferred Provider  
 (PPO)

Product Name: Individual Application

Project Name/Number: /

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form (revised)	Individual Application	Approved-Closed	Yes
Form	Individual Application	Approved-Closed	Yes

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**Amendment Letter**

Amendment Date:  
 Submitted Date: 04/23/2009

**Comments:**

An updated copy of application form AR HA-1 5/09 has been attached for your review.

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
AR HA-1 5/09	Application/Enrollment Form	Individual Application	Initial				40	AR HA-1 5-09 (filed).pdf

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## Form Schedule

**Lead Form Number:** AR HA-1 5/09

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	AR HA-1 5/09	Application/ Enrollment Form	Individual Application Initial			40	AR HA-1 5-09 (filed).pdf

# Arkansas Application for Individual Health Insurance Policies

Please complete application in blue or black ink.

Agent #: \_\_\_\_\_



39201 Seven Mile Road, Livonia, Michigan 48152-1094  
(800) 991-2642 (734) 591-9000 (734) 591-4628 Fax  
www.american-community.com

Thank you for applying to American Community Mutual Insurance Company (*herein referred to as American Community or AC*). Please take the time to carefully complete this application. Your answers will become part of the underwriting process and the insurance contract.

## A. TYPE OF APPLICATION

- New Application       Change to a new policy with AC. Current Policy # \_\_\_\_\_
- Add Dependents to Policy # \_\_\_\_\_ Key Insured \_\_\_\_\_
- (Please indicate information only on the dependents to be added to the policy.)
- [ • Was an American Community Short Term application submitted with this application?     Yes     No ]

## B. PERSONS APPLYING FOR INSURANCE

1. **List all Family Members applying for insurance.** Children must be at least [15] days old and under [22] years old. Include maiden names of females in parentheses. [To qualify as a full time (FT) student (for children between the ages of 18 and 22), a child must be enrolled in a minimum of 12 credit hours at a college, university, or trade school.]
- Check here if there are more than 3 dependent children. Attach a separate page listing the additional children.

Full Name First-Middle-Last (Include Maiden Name if used within past 5 yrs.)	Relationship to Applicant	Sex M/F	Date of Birth	Height FT. IN.	Weight LBS.	Social Security Number	✓ if FT Student
	Key Applicant						
	Spouse						
	Child						
	Child						
	Child						

### 2. Home Address

Street		
City	State	Zip
County		

### 3. Billing Address if other than Home Address

Name		
Street		
City	State	Zip

4. If any proposed applicant does not live at the above address, please explain: \_\_\_\_\_

### 5. Contact Numbers

Daytime Ph. #
Evening Ph. #
Spouse's Ph. #
E-mail Address

### 6. Occupation(s) If self-employed, please identify or describe your occupation.

Key Applicant Occupation:
Spouse Occupation:

### You may be contacted for a telephone interview.

Please indicate the best time (between 8:00 a.m. and 5:00 p.m. Eastern Standard Time) for an interview: \_\_\_\_\_

## C. EXISTING COVERAGE AND REPLACEMENT

Are any Applicants covered by other health insurance now?     Yes - Complete section below     No

Will this coverage be replaced by this policy if issued?     Yes     No - **Desired effective date:** \_\_\_\_\_

If health insurance is being replaced, replacement form [RAS-AR (2009)] must be signed and submitted with this application.

Applicant(s) Name(s)	Insurance Company Name	Group or Individual	Certificate or Policy Number	Effective Date	Termination Date

## D. BENEFITS REQUESTED

Please complete, sign and attach the [Arkansas Product Selection Form] identifying the Health Plan selected.

**E. PREMIUM PAYMENT INFORMATION**

Estimated monthly premium quoted by agent \$ \_\_\_\_\_

**INITIAL PREMIUM PAYMENT OPTIONS:** (make checks payable to American Community Mutual Insurance Company)

- Credit Card                       Check \$ \_\_\_\_\_                       EFT (Only if EFT is chosen as the billing option)

**INITIAL PREMIUM SHORTAGE OPTIONS:**

- Credit Card                       Bill Me                       EFT (Only if EFT is chosen as the billing option)

Please complete Credit Card and/or EFT information if you have selected them as a Premium Payment Option.

**CREDIT CARD**

(for initial payment only)

Card Holder Name: \_\_\_\_\_

Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

- MasterCard

Signature: X \_\_\_\_\_ Date signed: \_\_\_\_\_

- Visa

Signature: X \_\_\_\_\_ Date signed: \_\_\_\_\_

**BILLING FREQUENCY:**

- Monthly                       Quarterly\*                       Semi-Annually\*                       Annually\*

**BILLING OPTIONS:**

- Bill Me\*\*                       EFT (Electronic Fund Transfer)  
 New List Bill\*\* (List Bill Agreement Required)     List Bill # \_\_\_\_\_

Employer name for List Bill \_\_\_\_\_

\*Not available if EFT or List Bill is chosen as billing option.

\*\*Administrative Charge: Once approved, an additional Billing Fee of \$10 will be applied to each premium statement (fee is waived for EFT). List Bills include a \$25 Monthly Billing Fee.

**ELECTRONIC FUNDS TRANSFER (EFT)**

- Checking  
 Savings  
 (If allowed by bank)

Name of Financial Institution: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Account Holder's Name: \_\_\_\_\_

Transit Routing Number: \_\_\_\_\_ Account Number: \_\_\_\_\_

**Authorization Agreement For Electronic Funds Transfer for Premium Payment**

I authorize American Community Mutual Insurance Company (Company) to initiate monthly electronic withdrawals, in the amount of the then-current monthly premium rate, from the account and financial institution (Bank) named above. This authority remains in effect until Company and Bank receive written notification from me of its termination in such time and manner as to give Company and Bank a reasonable opportunity to act on it. Company reserves the right to void this agreement at any time without prior notice.

Signature: X \_\_\_\_\_ Date Signed: \_\_\_\_\_

Signature: X \_\_\_\_\_ Date Signed: \_\_\_\_\_

**Returned Check Fee:** If any premium payment made directly by check or by Electronic Funds Transfer (EFT) is returned for non-sufficient funds, a nonrefundable service fee will be charged.

**F. QUESTIONS APPLY TO EACH PERSON APPLYING FOR COVERAGE (APPLICANTS)**

Please answer all questions.

Yes No

Yes No

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>1. Are you, your spouse, significant other, or any dependent or adopted child now pregnant (whether or not this person is applying for coverage) or is there an adoption pending? <b>If yes, Do Not Submit Application.</b></p> <p>2. Are you a U.S. Citizen?</p> <p>3. Has any applicant lived outside the United States within the past 12 months or does any applicant plan to travel outside the United States in the next 12 months? If yes, who? _____<br/>Where? _____<br/>When? (give date range) _____</p> <p>4. Has any applicant smoked cigarettes, cigars, pipes or used any form of tobacco, including chewing tobacco or nicotine products?<br/>If yes, who? _____<br/>Form of tobacco used: _____<br/>Number of years used: _____<br/>How often did or do you use tobacco products? (ex. 10 cigarettes per day.) _____</p> | <p><input type="checkbox"/> <input type="checkbox"/></p> | <p>If quit, please provide date of last use: _____<br/>Why did you quit? _____</p> <p>5. Does any applicant engage in scuba or sky diving, organized racing, flying or other hazardous activities? If yes, who? _____<br/>What activity? _____</p> <p>6. Did or does any applicant consume, on average, more than 2 alcoholic beverages (<i>one beverage equals one 12 oz. beer or one 4 oz. wine or 1 oz. of liquor</i>) per day in the past 5 years? If yes, please complete the Alcohol/Drug Addendum.</p> <p>7. Has any applicant's driver's license been suspended or revoked in the last 5 years? If yes, please provide their name and driver's license number.<br/>Name: _____<br/>Driver's license number: _____<br/>If yes, and alcohol or drugs were related to suspension/revocation, please complete Alcohol/Drug Addendum.</p> | <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

(Section F continued)

Within the last 10 years, has any applicant had symptoms of; or a diagnosis of; or received treatment, including but not limited to medications for; or had testing for; or consulted with a physician or medical professional concerning ongoing monitoring or follow-up for any of the following:

Answer each question individually (please do not draw a continuous line through your answers) and document details of any "Yes" answers on page 4. American Community does not routinely request medical records during the underwriting process.

Table with 3 columns of medical conditions and checkboxes for 'Yes' and 'No'. Conditions include Abdominal Pain, Allergies, Arthritis, Diabetes, etc.

Has anyone applying for coverage ever (Document details of any "Yes" answers on page 4)

Table with 4 columns of questions and checkboxes for 'Yes' and 'No'. Questions include 'Been diagnosed or treated for any medical symptom...', 'Had any diagnostic testing...', etc.

Note: Benefits will be paid for a sickness, injury or condition that existed prior to the effective date of this policy, if approved, only if such sickness, injury, or condition is fully disclosed on this application and is not excluded from coverage by a rider or policy exclusion.

If any questions or conditions in section F are checked "Yes", please explain below (use additional paper, if necessary). Please indicate all details of the symptoms, injury, ailment or condition. Include items such as specific location of condition, diagnosis, type of treatment, testing, and/or hospitalization.

Question Number	Patient/Applicant	Condition, Injury, Symptom, or Diagnosis			Was recovery complete?	Treatment or advice given, surgery performed, diagnostic test results and medications prescribed	Name, address and phone number of doctors and hospitals
		Condition	Date began	Date last treated			

**PLEASE INCLUDE ANY DOCTOR/FACILITY LISTED ABOVE ON THE AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION. FAILURE TO LIST COMPLETE ADDRESSES AND PHONE NUMBERS OF DOCTORS/FACILITIES CAN RESULT IN DELAYED UNDERWRITING.**

**Additional Information:**

**G. CONSENT, TERMS AND CONDITIONS**

1. I represent that I have read this Application and understand each of the questions, and that the answers to each of the questions I have given are complete and true to the best of my knowledge. I agree that any misrepresentation on this Application will void my policy at the discretion of American Community. I further agree that if a policy is issued, it will be issued by American Community in full reliance and in consideration of the information, answers and statements contained herein. I understand that this application will be medically underwritten. I agree to provide American Community with any additional information that may be necessary to complete the underwriting process.
2. No contract, waiver, modification or change of contract shall be binding upon American Community unless it is in writing and signed by an authorized officer of American Community.
3. I represent that neither I, nor my spouse, is receiving any form of reimbursement or compensation for this coverage from any employer.
4. I understand and agree that no agent or broker has the authority: (i) to bind American Community by making promises regarding eligibility, benefits, or the issuance of a policy; (ii) to waive any answer or any portion of any answer to any question on this application or any information American Community requests; (iii) approve coverage; (iv) make or alter any contract on behalf of American Community; or (v) waive or alter any of American Community's other rights or requirements.
5. I consent to any consumer reporting agency that has any record, public record or knowledge of the character, general reputation, personal characteristics, mode of living or type of risk of any persons proposed for insurance to give to American Community, its legal representatives or its reinsurers, any such record or knowledge for purposes of underwriting insurance. This includes, but is not limited to, motor vehicle driving records and criminal history.
6. I consent to any physician, hospital, clinic, pharmacy, or other medical or medically related facility and insurance company, health information repository, its agents, business associates, or legal representatives to give to American Community, its legal representatives or its reinsurers any information or records or knowledge of the health, except for psychotherapy notes, of any persons proposed for insurance to carry out treatment, payment and health care operations.
7. An unaltered copy of this authorization is as valid as the original for 24 months from the date signed. I know that I, or my authorized representative, may request and are entitled to receive a copy of the consent. I know that I have the right to revoke this consent by notifying American Community in writing, except to the extent that American Community has taken action in reliance on this authorization.
8. I am signing this application on my own behalf and on behalf of all listed dependents. I understand that my statements and answers in this application must continue to be true as of the date I receive the policy. I understand that if my or my dependent's health or any of the answers or statements change prior to the underwriting decision date, I must inform American Community in writing. I understand that failure to do so may result in my application being denied or rescission of my or my dependent's coverage under the policy.
9. I understand that, unless required by law, the completion of this application and submission of any estimated initial premium does not: a.) provide interim coverage, b.) guarantee coverage, or c.) guarantee issue of a policy.
10. I acknowledge receipt of the Outline of Coverage for the health insurance plan selected on the Product Selection Form attached to this application.
11. I understand that the existence of other insurance may reduce the benefits under this plan.
12. I understand that this application is void if not approved within 90 days after the date the application was signed.

Signature of Key Applicant (or if minor Child, Parent or Guardian): X _____	Date: _____
Signature of Spouse: X _____	Date: _____
Signature of Dependent (age 18 or over): X _____	Date: _____

**WARNING:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Do not cancel any current health insurance coverage until you receive an approval letter and an insurance policy from American Community. You will be notified of the effective date of your policy.**

**PROXY**

The undersigned hereby appoints the President of American Community Mutual Insurance Company, with full power of substitution as the undersigned's proxy with full power, to vote and act on their behalf on all issues at all meetings of the members of the Company and any adjournments thereof. If the proxy named herein, or his named substitute, is for any reason unable to act, the Board of Directors of the Company may fill the place of such proxy by appointing another. The proxy named herein shall only vote for those persons to serve as directors who have been nominated by the Board of Directors of the Company. If such persons are unable or unwilling to serve, then the proxies named herein may select other nominees and vote for such other nominees to serve as directors. In addition, all other matters properly brought before the meeting of the members the proxy will vote in accord with the recommendation of the Board of Directors, if any, and, if none, according to his judgment. This proxy will continue in force for the period of time the undersigned is the named insured of a policy issued and in effect by the Company. The proxy may be revoked by the undersigned at any time by filing with the Secretary of the Company a written revocation, a duly executed proxy bearing a later date or by attending and voting in person at any meeting of the members.

Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

AGENT INFORMATION: Name: \_\_\_\_\_ Number: \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ Signature: X \_\_\_\_\_

**H. AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION:**

In order to comply with HIPAA privacy regulations and other privacy laws, I authorize any physician, medical professional, hospital, clinic, pharmacy, or other medical or medically related facility, insurance company, health information repository, medical record retrieval service as well as those entities listed below, and their agents, business associates and/or legal representatives to give to American Community Mutual Insurance Company, its legal representatives or its reinsures, any protected health information including medical records, lab work, x-rays, consultation reports, or knowledge of the health of the undersigned for underwriting purposes. This authorization also includes confidential communicable disease related information, confidential HIV-related information, and information about drug and alcohol use. This authorization permits disclosure of medical documents for 5 years prior to the date signed. This authorization includes all health related information except psychotherapy notes.

- 1. \_\_\_\_\_  
Key Applicant's Name Physician/Facility, Address and Phone Number
- 2. \_\_\_\_\_  
Spouse's Name Physician/Facility, Address and Phone Number
- 3. \_\_\_\_\_  
Child's Name Physician/Facility, Address and Phone Number
- 4. \_\_\_\_\_  
Child's Name Physician/Facility, Address and Phone Number
- 5. \_\_\_\_\_  
Child's Name Physician/Facility, Address and Phone Number

This authorization is valid for 24 months from the date below. A photographic copy of this authorization shall be as valid as the original for 24 months from the date below.

I understand and acknowledge that:

- 1. Execution of this authorization is required for eligibility and enrollment onto this plan. Failure to execute this authorization will result in denial of my application for enrollment.
- 2. I have the right to revoke this authorization by notifying American Community in writing, except to the extent that American Community has taken action in reliance on this authorization.
- 3. American Community must comply with federal privacy laws when using or disclosing health information. There may be times when the health information may be disclosed to another entity and the health information may no longer be protected by federal privacy laws, and may be disclosed by that entity. Examples of the types of entities not subject to federal privacy laws include, but are not limited to, business associates American Community uses to administer its benefits, regulators, and law enforcement officials.
- 4. If there are specific state laws regarding specific health conditions for which we cannot use this form to obtain health information about you, we will ask you to sign a state specific authorization form.

- 1. **X** \_\_\_\_\_  
Signature of key applicant\* Date Social Security Number Date of Birth
- 2. **X** \_\_\_\_\_  
Signature of spouse\* Date Social Security Number Date of Birth
- 3. **X** \_\_\_\_\_  
Signature of dependent (age 18 and over)\* Date Child's name Child's Social Security Number Date of Birth
- 4. **X** \_\_\_\_\_  
Signature of dependent (age 18 and over)\* Date Child's name Child's Social Security Number Date of Birth
- 5. **X** \_\_\_\_\_  
Signature of dependent (age 18 and over)\* Date Child's name Child's Social Security Number Date of Birth

\*If under the age of 18, the parent or guardian must sign on the child's behalf and indicate their relationship next to their signature. If you are the individual's representative and are not the parent of a minor, you must attach documentary evidence of your authority to act as the individual's representative for this authorization to be valid.

**Applicant MUST keep a copy of this authorization form and send a signed copy in with the application.**

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## Rate Information

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## Supporting Document Schedules

**Satisfied -Name:** Flesch Certification **Review Status:** Approved-Closed 05/01/2009  
**Comments:**  
**Attachments:**  
 AR HA-1 5-09 - Readability.pdf  
 AR HA-1 5-09 Cert of Unfair Sex Discrimination.pdf

**Bypassed -Name:** Application **Review Status:** Approved-Closed 05/01/2009  
**Bypass Reason:** N/A  
**Comments:**

**Bypassed -Name:** Health - Actuarial Justification **Review Status:** Approved-Closed 05/01/2009  
**Bypass Reason:** N/A  
**Comments:**

**Bypassed -Name:** Outline of Coverage **Review Status:** Approved-Closed 05/01/2009  
**Bypass Reason:** N/A  
**Comments:**

**AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY**  
39201 Seven Mile Road, Livonia, Michigan 48152  
734-591-9000 • FAX 734-591-4628  
NAIC Company #60305 • NAIC Group #166  
Oklahoma Company # 0326

**READABILITY CERTIFICATION**

TO: THE ARKANSAS DEPARTMENT OF INSURANCE

RE: Form Readability Certification

DATE: April 22, 2009

<u>Form Number</u>	<u>Description</u>
AR HA-1 5/09	Arkansas Application for Individual Health Insurance Policies

I certify that the above form meets or exceeds a score of forty (40) on the Flesch Readability Test.

\_\_\_\_\_  
Francis P. Dempsey, Senior Vice President  
General Counsel & Corporate Secretary

\_\_\_\_\_  
April 22, 2009

DATE

## **Certificate of Unfair Sex Discrimination**

I certify that we, American Community Mutual Insurance Company, are in compliance with Arkansas Rules and Regulation 19 – Unfair Sex Discrimination in the Sale of Insurance.

---

Francis P. Dempsey  
Senior Vice President & General Counsel

April 22, 2009

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Date

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## Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Individual Application	04/20/2009	AR HA-1 5-09.pdf

# Arkansas Application for Individual Health Insurance Policies

Please complete application in blue or black ink.

Thank you for applying to American Community Mutual Insurance Company (*herein referred to as American Community or AC*). Please take the time to carefully complete this application. Your answers will become part of the underwriting process and the insurance contract.

Agent #: \_\_\_\_\_



**AMERICAN COMMUNITY**  
MUTUAL INSURANCE COMPANY®

39201 Seven Mile Road Livonia, Michigan 48152-1094  
(800) 991-2642 (734) 591-9000  
www.american-community.com

## A. TYPE OF APPLICATION

- New Application       Change to a new policy with AC. Current Policy # \_\_\_\_\_
- Add Dependents to Policy # \_\_\_\_\_ Key Insured \_\_\_\_\_
- (Please indicate information only on the dependents to be added to the policy.)
- [ • Was an American Community Short Term application submitted with this application?     Yes     No ]

## B. PERSONS APPLYING FOR INSURANCE

- 1. List all Family Members applying for insurance.** Children must be at least [15] days old and under [22] years old. Include maiden names of females in parentheses. [To qualify as a full time (FT) student (for children between the ages of 18 and 22), a child must be enrolled in a minimum of 12 credit hours at a college, university, or trade school.]
- Check here if there are more than 3 dependent children. Attach a separate page listing the additional children.

Full Name First-Middle-Last <small>(Include Maiden Name if used within past 5 yrs.)</small>	Relationship to Applicant	Sex M/F	Date of Birth	Height FT. IN.	Weight LBS.	Social Security Number	✓ if FT Student
	Key Applicant						
	Spouse						
	Child						
	Child						
	Child						

**2. Home Address**

Street		
City	State	Zip
County		

**3. Billing Address if other than Home Address**

Name		
Street		
City	State	Zip

4. If any proposed applicant does not live at the above address, please explain: \_\_\_\_\_

**5. Contact Numbers**

Daytime Ph. #
Evening Ph. #
Spouse's Ph. #
E-mail Address

**6. Occupation(s)** If self-employed, please identify or describe your occupation.

Key Applicant Occupation:
Spouse Occupation:

**You may be contacted for a telephone interview.**  
Please indicate the best time (between 8:00 a.m. and 5:00 p.m. Eastern Standard Time) for an interview: \_\_\_\_\_

## C. EXISTING COVERAGE AND REPLACEMENT

Are any Applicants covered by other health insurance now?     Yes - Complete section below     No

Will this coverage be replaced by this policy if issued?     Yes     No - **Desired effective date:** \_\_\_\_\_

If health insurance is being replaced, replacement form [RAS-AR (2009)] must be signed and submitted with this application.

Applicant(s) Name(s)	Insurance Company Name	Group or Individual	Certificate or Policy Number	Effective Date	Termination Date

## D. BENEFITS REQUESTED

**Please complete, sign and attach the [Arkansas Product Selection Form] identifying the Health Plan selected.**

**E. PREMIUM PAYMENT INFORMATION**

Estimated monthly premium quoted by agent \$ \_\_\_\_\_

**INITIAL PREMIUM PAYMENT OPTIONS:** (make checks payable to American Community Mutual Insurance Company)

- Credit Card       Check \$ \_\_\_\_\_       EFT (Only if EFT is chosen as the billing option)

**INITIAL PREMIUM SHORTAGE OPTIONS:**

- Credit Card       Bill Me       EFT (Only if EFT is chosen as the billing option)

Please complete Credit Card and/or EFT information if you have selected them as a Premium Payment Option.

**CREDIT CARD**

(for initial payment only)

Card Holder Name: \_\_\_\_\_

Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**MasterCard**      **Signature: X** \_\_\_\_\_ Date signed: \_\_\_\_\_

**Visa**      **Signature: X** \_\_\_\_\_ Date signed: \_\_\_\_\_

**BILLING FREQUENCY:**

- Monthly       Quarterly\*       Semi-Annually\*       Annually\*

**BILLING OPTIONS:**

- Bill Me\*\*       EFT (Electronic Fund Transfer)
- New List Bill\*\* (List Bill Agreement Required)       List Bill # \_\_\_\_\_

Employer name for List Bill \_\_\_\_\_

\*Not available if EFT or List Bill is chosen as billing option.

\*\*Administrative Charge: Once approved, an additional Billing Fee of \$10 will be applied to each premium statement (fee is waived for EFT). List Bills include a \$25 Monthly Billing Fee.

**ELECTRONIC FUNDS TRANSFER (EFT)**

- Checking
  - Savings
- (If allowed by bank)

Name of Financial Institution: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Account Holder's Name: \_\_\_\_\_

Transit Routing Number: \_\_\_\_\_ Account Number: \_\_\_\_\_

**Authorization Agreement For Electronic Funds Transfer for Premium Payment**

I authorize American Community Mutual Insurance Company (Company) to initiate monthly electronic withdrawals, in the amount of the then-current monthly premium rate, from the account and financial institution (Bank) named above. This authority remains in effect until Company and Bank receive written notification from me of its termination in such time and manner as to give Company and Bank a reasonable opportunity to act on it. Company reserves the right to void this agreement at any time without prior notice.

**Signature: X** \_\_\_\_\_ Date Signed: \_\_\_\_\_

**Signature: X** \_\_\_\_\_ Date Signed: \_\_\_\_\_

**Returned Check Fee:** If any premium payment made directly by check or by Electronic Funds Transfer (EFT) is returned for non-sufficient funds, a nonrefundable service fee will be charged.

**F. QUESTIONS APPLY TO EACH PERSON APPLYING FOR COVERAGE (APPLICANTS)**

Please answer all questions.

Yes No

Yes No

1. Are you, your spouse, significant other, or any dependent or adopted child now pregnant (whether or not this person is applying for coverage) or is there an adoption pending? **If yes, Do Not Submit Application.**

If quit, please provide date of last use: \_\_\_\_\_  
Why did you quit? \_\_\_\_\_

5. Does any applicant engage in scuba or sky diving, organized racing, flying or other hazardous activities?

If yes, who? \_\_\_\_\_  
What activity? \_\_\_\_\_

2. Are you a U.S. Citizen?

3. Has any applicant lived outside the United States within the past 12 months or does any applicant plan to travel outside the United States in the next 12 months? If yes, who? \_\_\_\_\_

6. Did or does any applicant consume, on average, more than 2 alcoholic beverages (one beverage equals one 12 oz. beer or one 4 oz. wine or 1 oz. of liquor) per day in the past 5 years? If yes, please complete the Alcohol/Drug Addendum.

4. Has any applicant smoked cigarettes, cigars, pipes or used any form of tobacco, including chewing tobacco or nicotine products?

7. Has any applicant's driver's license been suspended or revoked in the last 5 years? If yes, please provide their name and driver's license number.

If yes, who? \_\_\_\_\_  
Form of tobacco used: \_\_\_\_\_  
Number of years used: \_\_\_\_\_  
How often did or do you use tobacco products? (ex. 10 cigarettes per day.) \_\_\_\_\_

Name: \_\_\_\_\_  
Driver's license number: \_\_\_\_\_  
If yes, and alcohol or drugs were related to suspension/revocation, please complete Alcohol/Drug Addendum.

(Section F continued)

Within the last 10 years, has any applicant had symptoms of; or a diagnosis of; or received treatment, including but not limited to medications for; or had testing for; or consulted with a physician or medical professional concerning ongoing monitoring or follow-up for any of the following:

**Answer each question individually (please do not draw a continuous line through your answers) and document details of any "Yes" answers on page 4. American Community does not routinely request medical records during the underwriting process.**

	Yes	No		Yes	No		Yes	No
8. Abdominal Pain .....	<input type="checkbox"/>	<input type="checkbox"/>	42. Ear Infections .....	<input type="checkbox"/>	<input type="checkbox"/>	76. Lymphadenopathy .....	<input type="checkbox"/>	<input type="checkbox"/>
9. Abnormal test results.....	<input type="checkbox"/>	<input type="checkbox"/>	43. Eating Disorders .....	<input type="checkbox"/>	<input type="checkbox"/>	77. Lymphoma .....	<input type="checkbox"/>	<input type="checkbox"/>
10. ADD/ADHD.....	<input type="checkbox"/>	<input type="checkbox"/>	44. Edema .....	<input type="checkbox"/>	<input type="checkbox"/>	78. Male Genital Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>
11. Adrenal Gland Disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	45. Elevated cholesterol .....	<input type="checkbox"/>	<input type="checkbox"/>	79. Mental Health .....	<input type="checkbox"/>	<input type="checkbox"/>
12. Alcohol/Drug/ Substance Abuse .....	<input type="checkbox"/>	<input type="checkbox"/>	46. Elevated Triglycerides .....	<input type="checkbox"/>	<input type="checkbox"/>	80. Miscarriage .....	<input type="checkbox"/>	<input type="checkbox"/>
13. Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	47. Emphysema .....	<input type="checkbox"/>	<input type="checkbox"/>	81. Multiple sclerosis .....	<input type="checkbox"/>	<input type="checkbox"/>
14. Alzheimer's.....	<input type="checkbox"/>	<input type="checkbox"/>	48. Endocrine Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	82. Muscular dystrophy .....	<input type="checkbox"/>	<input type="checkbox"/>
15. Anemia .....	<input type="checkbox"/>	<input type="checkbox"/>	49. Eye Disorders .....	<input type="checkbox"/>	<input type="checkbox"/>	83. Nervous System Disorders ..	<input type="checkbox"/>	<input type="checkbox"/>
16. Aneurysm .....	<input type="checkbox"/>	<input type="checkbox"/>	50. Female Disorders .....	<input type="checkbox"/>	<input type="checkbox"/>	84. Numbness or tingling .....	<input type="checkbox"/>	<input type="checkbox"/>
17. Anxiety/Depression .....	<input type="checkbox"/>	<input type="checkbox"/>	51. Fibromyalgia .....	<input type="checkbox"/>	<input type="checkbox"/>	85. Osteoporosis/Osteopenia ...	<input type="checkbox"/>	<input type="checkbox"/>
18. Arthritis/gout .....	<input type="checkbox"/>	<input type="checkbox"/>	52. Foot Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	86. Pancreas Disorders .....	<input type="checkbox"/>	<input type="checkbox"/>
19. Artificial limb or prosthesis....	<input type="checkbox"/>	<input type="checkbox"/>	53. Gallbladder Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	87. Paralysis .....	<input type="checkbox"/>	<input type="checkbox"/>
20. Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>	54. Gastric bypass .....	<input type="checkbox"/>	<input type="checkbox"/>	88. Phlebitis .....	<input type="checkbox"/>	<input type="checkbox"/>
21. Autism .....	<input type="checkbox"/>	<input type="checkbox"/>	55. Gastric reflux (GERD) .....	<input type="checkbox"/>	<input type="checkbox"/>	89. Pituitary Disorders .....	<input type="checkbox"/>	<input type="checkbox"/>
22. Autoimmune Disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	56. Headaches/Migraines .....	<input type="checkbox"/>	<input type="checkbox"/>	90. Pneumonia .....	<input type="checkbox"/>	<input type="checkbox"/>
23. Back or spine Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	57. Hearing Impairment .....	<input type="checkbox"/>	<input type="checkbox"/>	91. Polyp .....	<input type="checkbox"/>	<input type="checkbox"/>
24. Bladder Disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	58. Heart attack .....	<input type="checkbox"/>	<input type="checkbox"/>	92. Pregnancy Complications ...	<input type="checkbox"/>	<input type="checkbox"/>
25. Blood Disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	59. Heart Disorders .....	<input type="checkbox"/>	<input type="checkbox"/>	93. Prostate Disorders .....	<input type="checkbox"/>	<input type="checkbox"/>
26. Breast Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	60. Heart murmur .....	<input type="checkbox"/>	<input type="checkbox"/>	94. Rectal bleeding .....	<input type="checkbox"/>	<input type="checkbox"/>
27. Bronchitis.....	<input type="checkbox"/>	<input type="checkbox"/>	61. Hemorrhoids .....	<input type="checkbox"/>	<input type="checkbox"/>	95. Reproductive System Disorders .....	<input type="checkbox"/>	<input type="checkbox"/>
28. Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	62. Hernia .....	<input type="checkbox"/>	<input type="checkbox"/>	96. Respiratory Disorders .....	<input type="checkbox"/>	<input type="checkbox"/>
29. Carpal Tunnel Syndrome.....	<input type="checkbox"/>	<input type="checkbox"/>	63. High Blood Pressure (provide last 3 pressures and dates) .....	<input type="checkbox"/>	<input type="checkbox"/>	97. Shoulder Disorder/Injury .....	<input type="checkbox"/>	<input type="checkbox"/>
30. Cerebral Palsy.....	<input type="checkbox"/>	<input type="checkbox"/>	64. Hodgkin's Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	98. Sinus infections .....	<input type="checkbox"/>	<input type="checkbox"/>
31. Cesarean Section.....	<input type="checkbox"/>	<input type="checkbox"/>	65. Infertility .....	<input type="checkbox"/>	<input type="checkbox"/>	99. Skin condition .....	<input type="checkbox"/>	<input type="checkbox"/>
32. Chest Pain.....	<input type="checkbox"/>	<input type="checkbox"/>	66. Intestinal Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	100. Sleep Disorders .....	<input type="checkbox"/>	<input type="checkbox"/>
33. Chronic fatigue syndrome ....	<input type="checkbox"/>	<input type="checkbox"/>	67. Irregular heartbeat .....	<input type="checkbox"/>	<input type="checkbox"/>	101. Speech Impairment .....	<input type="checkbox"/>	<input type="checkbox"/>
34. Chronic Obstructive Pulmonary Disease (COPD) ..	<input type="checkbox"/>	<input type="checkbox"/>	68. Irritable bowel syndrome ....	<input type="checkbox"/>	<input type="checkbox"/>	102. Thyroid Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>
35. Colitis .....	<input type="checkbox"/>	<input type="checkbox"/>	69. Joint Disorders/ Replacement .....	<input type="checkbox"/>	<input type="checkbox"/>	103. TemporoMandibular Joint (TMJ) .....	<input type="checkbox"/>	<input type="checkbox"/>
36. Colon polyps .....	<input type="checkbox"/>	<input type="checkbox"/>	70. Kidney Disorders .....	<input type="checkbox"/>	<input type="checkbox"/>	104. Tonsils/Adenoids .....	<input type="checkbox"/>	<input type="checkbox"/>
37. Convulsions/Seizures .....	<input type="checkbox"/>	<input type="checkbox"/>	71. Knee Disorder/injury .....	<input type="checkbox"/>	<input type="checkbox"/>	105. Transient Ischemic Attack (TIA)/Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>
38. Crohn's Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	72. Leukemia .....	<input type="checkbox"/>	<input type="checkbox"/>	106. Tremors .....	<input type="checkbox"/>	<input type="checkbox"/>
39. Cyst .....	<input type="checkbox"/>	<input type="checkbox"/>	73. Liver Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	107. Tumor/Nodule .....	<input type="checkbox"/>	<input type="checkbox"/>
40. Diabetes or High Blood Sugar .....	<input type="checkbox"/>	<input type="checkbox"/>	74. Lupus .....	<input type="checkbox"/>	<input type="checkbox"/>	108. Ulcer .....	<input type="checkbox"/>	<input type="checkbox"/>
41. Digestive Disorders .....	<input type="checkbox"/>	<input type="checkbox"/>	75. Lyme Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	109. Varicose veins .....	<input type="checkbox"/>	<input type="checkbox"/>
						110. Vertigo or Dizziness .....	<input type="checkbox"/>	<input type="checkbox"/>

**Has anyone applying for coverage ever (Document details of any "Yes" answers on page 4)**

	Yes	No		Yes	No
111. Been diagnosed or treated for any medical symptom or condition not listed above?	<input type="checkbox"/>	<input type="checkbox"/>	117. Been tested positive for, been diagnosed as having, or been treated for:		
112. Had any diagnostic testing, treatment, or surgery recommended or scheduled that has not been completed?	<input type="checkbox"/>	<input type="checkbox"/>	a. Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/>	<input type="checkbox"/>
113. Had any symptoms or conditions for which a prudent person would seek medical advice or treatment?	<input type="checkbox"/>	<input type="checkbox"/>	b. Hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
114. Taken, or currently take, any medication?	<input type="checkbox"/>	<input type="checkbox"/>	c. Sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>
115. Had or have Breast Implants or Internal Fixation (plates, screws, pins, shunts, stents, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	118. When was the last time you consulted a health care provider? _____		
116. Had a routine medical exam with blood work, or routine PAP Smear or well child exam?	<input type="checkbox"/>	<input type="checkbox"/>	Why? _____		
			Were there any abnormal findings, recommendations for follow up or recommended testing, treatments, procedures, referrals or prescriptions? If yes, please document details on page 4.	<input type="checkbox"/>	<input type="checkbox"/>

**Note:** Benefits will be paid for a sickness, injury or condition that existed prior to the effective date of this policy, if approved, only if such sickness, injury, or condition is fully disclosed on this application and is not excluded from coverage by a rider or policy exclusion.



**G. CONSENT, TERMS AND CONDITIONS**

1. I represent that I have read this Application and understand each of the questions, and that the answers to each of the questions I have given are complete and true to the best of my knowledge. I agree that any misrepresentation on this Application will void my policy at the discretion of American Community. I further agree that if a policy is issued, it will be issued by American Community in full reliance and in consideration of the information, answers and statements contained herein. I understand that this application will be medically underwritten. I agree to provide American Community with any additional information that may be necessary to complete the underwriting process.
2. No contract, waiver, modification or change of contract shall be binding upon American Community unless it is in writing and signed by an authorized officer of American Community.
3. I represent that neither I, nor my spouse, is receiving any form of reimbursement or compensation for this coverage from any employer.
4. I understand and agree that no agent or broker has the authority: (i) to bind American Community by making promises regarding eligibility, benefits, or the issuance of a policy; (ii) to waive any answer or any portion of any answer to any question on this application or any information American Community requests; (iii) approve coverage; (iv) make or alter any contract on behalf of American Community; or (v) waive or alter any of American Community's other rights or requirements.
5. I consent to any consumer reporting agency that has any record, public record or knowledge of the character, general reputation, personal characteristics, mode of living or type of risk of any persons proposed for insurance to give to American Community, its legal representatives or its reinsurers, any such record or knowledge for purposes of underwriting insurance. This includes, but is not limited to, motor vehicle driving records and criminal history.
6. I consent to any physician, hospital, clinic, pharmacy, or other medical or medically related facility and insurance company, health information repository, its agents, business associates, or legal representatives to give to American Community, its legal representatives or its reinsurers any information or records or knowledge of the health, except for psychotherapy notes, of any persons proposed for insurance to carry out treatment, payment and health care operations.
7. An unaltered copy of this authorization is as valid as the original for 24 months from the date signed. I know that I, or my authorized representative, may request and are entitled to receive a copy of the consent. I know that I have the right to revoke this consent by notifying American Community in writing, except to the extent that American Community has taken action in reliance on this authorization.
8. I am signing this application on my own behalf and on behalf of all listed dependents. I understand that my statements and answers in this application must continue to be true as of the date I receive the policy. I understand that if my or my dependent's health or any of the answers or statements change prior to the underwriting decision date, I must inform American Community in writing. I understand that failure to do so may result in my application being denied or rescission of my or my dependent's coverage under the policy.
9. I understand that, unless required by law, the completion of this application and submission of any estimated initial premium does not: a.) provide interim coverage, b.) guarantee coverage, or c.) guarantee issue of a policy.
10. I acknowledge receipt of the Outline of Coverage for the health insurance plan selected on the Product Selection Form attached to this application.
11. I understand that the existence of other insurance may reduce the benefits under this plan.
12. I understand that this application is void if not approved within 90 days after the date the application was signed.

Signature of Key Applicant (or if minor Child, Parent or Guardian): X _____	Date: _____
Signature of Spouse: X _____	Date: _____
Signature of Dependent (age 18 or over): X _____	Date: _____

**WARNING:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Do not cancel any current health insurance coverage until you receive an approval letter and an insurance policy from American Community. You will be notified of the effective date of your policy.**

**PROXY**

The undersigned hereby appoints the President of American Community Mutual Insurance Company, with full power of substitution as the undersigned's proxy with full power, to vote and act on their behalf on all issues at all meetings of the members of the Company and any adjournments thereof. If the proxy named herein, or his named substitute, is for any reason unable to act, the Board of Directors of the Company may fill the place of such proxy by appointing another. The proxy named herein shall only vote for those persons to serve as directors who have been nominated by the Board of Directors of the Company. If such persons are unable or unwilling to serve, then the proxies named herein may select other nominees and vote for such other nominees to serve as directors. In addition, all other matters properly brought before the meeting of the members the proxy will vote in accord with the recommendation of the Board of Directors, if any, and, if none, according to his judgment. This proxy will continue in force for the period of time the undersigned is the named insured of a policy issued and in effect by the Company. The proxy may be revoked by the undersigned at any time by filing with the Secretary of the Company a written revocation, a duly executed proxy bearing a later date or by attending and voting in person at any meeting of the members.

Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

AGENT INFORMATION: Name: \_\_\_\_\_ Number: \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ Signature: X \_\_\_\_\_

**H. AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION:**

In order to comply with HIPAA privacy regulations and other privacy laws, I authorize any physician, medical professional, hospital, clinic, pharmacy, or other medical or medically related facility, insurance company, health information repository, medical record retrieval service as well as those entities listed below, and their agents, business associates and/or legal representatives to give to American Community Mutual Insurance Company, its legal representatives or its reinsures, any protected health information including medical records, lab work, x-rays, consultation reports, or knowledge of the health of the undersigned for underwriting purposes. This authorization also includes confidential communicable disease related information, confidential HIV-related information, and information about drug and alcohol use. This authorization permits disclosure of medical documents for 5 years prior to the date signed. This authorization includes all health related information except psychotherapy notes.

- 1. \_\_\_\_\_  
Key Applicant's Name Physician/Facility, Address and Phone Number
- 2. \_\_\_\_\_  
Spouse's Name Physician/Facility, Address and Phone Number
- 3. \_\_\_\_\_  
Child's Name Physician/Facility, Address and Phone Number
- 4. \_\_\_\_\_  
Child's Name Physician/Facility, Address and Phone Number
- 5. \_\_\_\_\_  
Child's Name Physician/Facility, Address and Phone Number

This authorization is valid for 24 months from the date below. A photographic copy of this authorization shall be as valid as the original for 24 months from the date below.

I understand and acknowledge that:

- 1. Execution of this authorization is required for eligibility and enrollment onto this plan. Failure to execute this authorization will result in denial of my application for enrollment.
- 2. I have the right to revoke this authorization by notifying American Community in writing, except to the extent that American Community has taken action in reliance on this authorization.
- 3. American Community must comply with federal privacy laws when using or disclosing health information. There may be times when the health information may be disclosed to another entity and the health information may no longer be protected by federal privacy laws, and may be disclosed by that entity. Examples of the types of entities not subject to federal privacy laws include, but are not limited to, business associates American Community uses to administer its benefits, regulators, and law enforcement officials.
- 4. If there are specific state laws regarding specific health conditions for which we cannot use this form to obtain health information about you, we will ask you to sign a state specific authorization form.

- 1. **X** \_\_\_\_\_  
Signature of key applicant\* Date Social Security Number Date of Birth
- 2. **X** \_\_\_\_\_  
Signature of spouse\* Date Social Security Number Date of Birth
- 3. **X** \_\_\_\_\_  
Signature of dependent (age 18 and over)\* Date Child's name Child's Social Security Number Date of Birth
- 4. **X** \_\_\_\_\_  
Signature of dependent (age 18 and over)\* Date Child's name Child's Social Security Number Date of Birth
- 5. **X** \_\_\_\_\_  
Signature of dependent (age 18 and over)\* Date Child's name Child's Social Security Number Date of Birth

\*If under the age of 18, the parent or guardian must sign on the child's behalf and indicate their relationship next to their signature. If you are the individual's representative and are not the parent of a minor, you must attach documentary evidence of your authority to act as the individual's representative for this authorization to be valid.

**Applicant MUST keep a copy of this authorization form and send a signed copy in with the application.**

## NOTICE OF YOUR PRIVACY RIGHTS

We know that your trust in us is very important. We are committed to protecting your privacy rights. Please read this document carefully. It discloses your privacy rights.

**Obtaining Information About You** - We may obtain information from your application, a telephone interview with you, claims history with us, policies you have or had with us, account balances and premium payment history, and other sources, such as health care providers (medical information), and consumer reporting agencies (credit reports). Your address, birthday, telephone number, social security number are examples of such information. You may have to share such information with us, our affiliates, agencies or others working with us.

**Our Use of Personal Information** - We will share such information only with companies associated with us. We, or your agent or broker may use your information to offer you products or help you choose a product.

We may, as permitted by the law and without your prior approval, give information about you to persons who do business for us, your agent or broker, other insurance companies, or other persons handling your business, insurance company support organizations, regulatory or law enforcement authorities; and our affiliated companies. Information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons.

### Your Rights

- The right to access, inspect and copy the personal information pertaining to you that we maintain in our files about you.
- The right to request that we correct or amend any personal information that we have about you.

To exercise these rights, please send a written request to the attention of the Privacy Coordinator.

**How We Protect Your Personal Information** - We protect the information we share with companies working for us through an agreement. The agreement obligates those companies to keep your information confidential.

Only our employees who work to service your business see your personal information. We have trained our employees to closely follow our privacy rules for your protection. Your privacy rights will continue if you cease to be our customer.

**THE REMAINDER OF 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.**

We are required to maintain the privacy of your personal medical information and provide you with this notice as to our legal duties and privacy practices. We are required to abide by the terms of this notice. We reserve the right to change the terms of this notice and to make any new provisions effective to all of the medical information that we maintain about you. If we revise this notice, we will provide you with a revised notice by mailing the revised notice to the address you have supplied us.

### STATEMENT OF YOUR RIGHTS

You have the right to know how we use or disclose your personal medical information. There are certain uses and disclosures of your personal medical information that we are permitted or required to make by law without your permission. In addition, you have:

- The right to request that we place additional restrictions on our uses and disclosures of your personal medical information, but we are not obligated to agree to any such restrictions.
- The right to access, inspect and copy the protected information pertaining to you that we maintain in our files, and the right to request that we correct or amend any personal medical information that we have about you.
- The right to receive an accounting of the disclosures of your personal medical information that we make for purposes other than activities related to your treatment, or our payment functions or other health care operations.
- The right to request that you receive communications of personal medical information in a confidential manner.
- The right to obtain a paper copy of this notice from us on request.

To exercise these rights please send a written request to the attention of the Privacy Coordinator.

### PERMISSIBLE USES AND DISCLOSURES OF PROTECTED MEDICAL INFORMATION

**Payment Functions.** We may use or disclose your protected medical information without your permission to carry out activities relating to reimbursing you for the provision of health care, obtaining premiums, determining coverage, and providing benefits under the policy of insurance that you are purchasing. For example, payment functions may include (but are not limited to) reviewing health care services with respect to medical necessity, coverage under the policy, appropriateness of care, or justification of charges.

**Health Care Operations.** We may also use or disclose your protected medical information without your permission to carry out certain insurance-related activities. For example, these activities include using your protected information for underwriting, premium rating, or other activities relating to the creation, renewal or replacement of another contract of health

insurance, placing a contract for reinsurance of risk relating to claims for health care, and performing audit functions to ensure compliance and proper claims payment.

**Group Health Plan.** We may disclose your protected medical information to your employer as necessary for the purpose of reporting claims experience or conducting an audit if you are covered under an employer-based group health insurance plan.

**Business Associates.** We may disclose your protected medical information to our business associates. There are some services provided in our company through contracts with our business associates.

**Uses Permitted By Law.** We may also use or disclose your protected medical information without your written permission for purposes permitted or required by law.

**Authorized Uses.** All other disclosures of your protected medical information will be made only with your written permission, and any permission that you give us may be revoked by you at any time.

**COMPLAINTS ABOUT MISUSE OF INFORMATION** - If you believe your privacy rights have been violated you may complain either directly to us or to the Secretary of Health and Human Services (H.H.S.). Please submit all complaints in writing to us or H.H.S. as follows:

American Community Mutual Insurance Company

Attn: Privacy Officer  
39201 Seven Mile Road  
Livonia, MI 48152

U.S. Department of Health and Human Services (H.H.S.)

Attn: Secretary  
200 Independence Ave. S.W.  
Washington, DC 20201

You will not be retaliated against in any way for filing a complaint.

**OBTAINING FURTHER INFORMATION** - Please call American Community at (800) 991-2642 if you have any questions or comments.

Effective: December 1, 2007