

SERFF Tracking Number: USHG-126148077 State: Arkansas  
Filing Company: Freedom Life Insurance Company of America State Tracking Number: 42363  
Company Tracking Number: PPO RATE-AE-09-FLIC  
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.002A Large Group Only - PPO  
Product Name: PPO-RATE-AE-FLIC  
Project Name/Number: /

## Filing at a Glance

Company: Freedom Life Insurance Company of America

Product Name: PPO-RATE-AE-FLIC SERFF Tr Num: USHG-126148077 State: ArkansasLH  
TOI: H16G Group Health - Major Medical SERFF Status: Closed State Tr Num: 42363  
Sub-TOI: H16G.002A Large Group Only - PPO Co Tr Num: PPO RATE-AE-09-FLIC State Status: Approved-Closed  
Filing Type: Form Co Status: Reviewer(s): Rosalind Minor  
Author: Shari McBride Disposition Date: 05/18/2009  
Date Submitted: 05/12/2009 Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

## General Information

Project Name: Status of Filing in Domicile: Pending  
Project Number: Date Approved in Domicile:  
Requested Filing Mode: Review & Approval Domicile Status Comments: Filed concurrently.  
Explanation for Combination/Other: Market Type: Group  
Submission Type: New Submission Group Market Size: Large  
Overall Rate Impact: Group Market Type: Association  
Filing Status Changed: 05/18/2009 Explanation for Other Group Market Type:  
State Status Changed: 05/18/2009  
Deemer Date: Corresponding Filing Tracking Number:  
Filing Description:  
RE: Freedom Life Insurance Company of America  
NAIC 62324 FEIN #61-1096685  
New Submission

Forms

PPO RATE-AE-09-FLIC Amendatory Endorsement

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APP-09-NOARB-FLIC Application

Dear Commissioner Bradford:

Enclosed are the referenced form for your review and approval. These forms are new and not intended to replace any forms previously approved or filed with your Department.

This first form is intended to allow rate changes based on participating provider network changes. The amended language includes the following items:

a change occurs in the relationship between Us and Your Participating Provider network;  
the Participating Provider network availability changes for Your state;  
the Participating Provider negotiated discounts changes;

This form will be attached to any form approved by / filed with the Department that utilizes Participating Providers.

The application is filed bracketed / variable in order to accommodate different marketing organizations and product offerings.

We also reserve the right to amend the referenced forms to correct any minor typographical errors we may have neglected to find prior to submitting for approval, and to amend the language in order to clarify the intent within the confines of the law.

## Company and Contact

### Filing Contact Information

Shari McBride, Product Analyst mcbrides@ushealthgroup.com  
801 Cherry Street, Unit 33 (800) 221-9039 [Phone]  
Fort Worth, TX 76102 (817) 878-3422[FAX]

### Filing Company Information

Freedom Life Insurance Company of America CoCode: 62324 State of Domicile: Texas  
3100 Burnett Plaza Group Code: 839 Company Type: Accident, Life and

SERFF Tracking Number: USHG-126148077 State: Arkansas  
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Product Name: PPO-RATE-AE-FLIC  
Project Name/Number: /

Health

801 Cherry Street, Unit 33  
Fort Worth, TX 76102  
(817) 878-3328 ext. [Phone]

Group Name:  
FEIN Number: 61-1096685

State ID Number:

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## Filing Fees

Fee Required? Yes  
Fee Amount: \$100.00  
Retaliatory? Yes  
Fee Explanation: \$50 per form.  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Freedom Life Insurance Company of America	\$100.00	05/12/2009	27809166

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/18/2009	05/18/2009

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## Disposition

Disposition Date: 05/18/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Form</b>	PPO rate language	Approved-Closed	Yes
<b>Form</b>	Application	Approved-Closed	Yes

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## Form Schedule

**Lead Form Number:** PPO-RATE-AE-09-FLIC

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	PPO-RATE-AE-09-FLIC	Certificate Amendment, Insert Page, Endorsement or Rider	PPO rate language	Initial		53	PPO-RATE-AE-09-FLIC.pdf
Approved-Closed	APP-09-NOARB-FLIC	Application/ Enrollment Form	Application	Initial		53	APP-09-FLIC - noarb.pdf

# FREEDOM LIFE INSURANCE COMPANY OF AMERICA

[3100 Burnett Plaza 801 Cherry Street, Unit 33 Fort Worth, Texas 76102 1-800-387-9027]

## AMENDATORY ENDORSEMENT

This Amendatory Endorsement is issued to and made a part of the **Certificate** to which it is attached. This Amendatory Endorsement changes **Your Certificate** as follows:

1. The definition of **Premium Rate Guarantee Period** is hereby deleted in its entirety and replaced with the following:

**"Premium Rate Guarantee Period"** means the number of months immediately following the **Issue Date** that must expire before the amount of **Renewal Premium** charged by **Us** (with the same **Mode of Premium Payment** as the **Mode of Premium Payment** selected for payment of the **Initial Premium**) can be higher than the amount of the **Initial Premium** because of (i) a change by **Us** in the table of premium rates used to calculate the **Initial Premium**, or (ii) an increase in the attained age after the **Issue Date** of any **Insured** listed on the **Certificate Schedule**. However, the amount of **Renewal Premium** required for this **Certificate** may be increased by **Us**, even during the **Premium Rate Guarantee Period**, if after the **Issue Date**:

1. **You add Insureds** to this **Certificate**;
2. **You change** the amount of the **Calendar Year [Single] Deductible** shown on the **Certificate Schedule**;
3. **You change** the **Insured Coinsurance Percentage** shown on the **Certificate Schedule**;
4. **You change** any other coverage option;
5. **You change** residence to a different ZIP code;
6. **You change** the **Mode Of Premium Payment**;
7. **You add** optional coverage riders, if any;
8. **You change** to a different optional **Participating Provider** network available in **Your** state, if any;
9. a change occurs in the relationship between **Us** and **Your Participating Provider** network;
10. the **Participating Provider** network availability changes for **Your** state;
11. the **Participating Provider** negotiated discounts change; and/or
12. a change occurs in **Sickness and Injury Benefits, Wellness and Screening Benefits**, and/or the **Miscellaneous Benefits** by amendatory endorsement pursuant to any federal or state law or regulation.

2. The **IV. PREMIUM** Section of the **Certificate** is hereby deleted in its entirety and replaced with the following:

### A. INITIAL PREMIUM

The **Initial Premium** specified on the **Certificate Schedule** is due and payable to the **Company** at its home office on or before the **Issue Date**. This **Initial Premium** payment will keep this **Certificate** in force until the **First Renewal Date**. The amount of the **Initial Premium** and the **First Renewal Date** are shown on the **Certificate Schedule**. **Initial Premium** has been determined by **Us** for this **Certificate** on a **Class** basis. **Your Class** for **Initial Premium** was determined by **Us** based upon several factors, including, among other things, a combination of the following: (i) **Your** zip code (either first 3 or first 5 digits); (ii) **Your** county of residence; (iii) **Your** state of residence; (iv) the number, age, sex and tobacco use of each **Insured** listed on the **Certificate Schedule**; (v) the plan of coverage contained in this **Certificate** on the **Issue Date**, including its deductibles, **Benefits**, limitations, and exclusions; (vi) the health status of each applicant, including the results of any required physical examination and laboratory test results; (vii) **Participating Provider** network selected on the application, (viii) the underwriting risk assessment of each **Insured**; (ix) the discounted or preferred premium rate status of any **Insured**; (x) premium rate ups, if any, for any **Insured**; (xi) **Mode Of Premium Payment** selected on the application; (xii) distribution channels; (xiii) administrative costs; (xiv) taxes; (xv) other economic factors; and/or (xvi) other certificates of coverage issued and to be issued by **Us** covering individuals in **Your** current state of residence with the same or similar attained factors described above.

### B. RENEWAL PREMIUM

#### 1. CALCULATION - PAYMENT

The current **Mode Of Premium Payment** is shown on the **Certificate Schedule**. **Renewal Premium** is payable on or before its due date, and must be paid to the **Company** at its home office. Any **Renewal Premium** not paid on or before its due date is a premium in default. If a **Renewal Premium** payment default is not corrected and properly paid before the end of the grace period, coverage under this **Certificate** will terminate.

**Renewal Premium** rates for this **Certificate** may be increased by **Us** for any renewal period after the **Issue Date**, including during the **Premium Rate Guarantee Period**, if after the **Issue Date**:

- a. **You** add **Insureds** to this **Certificate**;
- b. **You** change the amount of the **Calendar Year [Single] Deductible** shown on the **Certificate Schedule**;
- c. **You** change the **Insured Coinsurance Percentage** shown on the **Certificate Schedule**;
- d. **You** change any other coverage option;
- e. **You** change residence to a different ZIP code;
- f. **You** change the **Mode Of Premium Payment**;
- g. **You** add optional coverage riders, if any;
- h. **You** change to a different optional **Participating Provider** network available in **Your** state, if any;
- i. a change occurs in the relationship between **Us** and **Your Participating Provider** network;
- j. the **Participating Provider** network availability changes for **Your** state;
- k. the **Participating Provider** negotiated discounts change; and/or
- l. a change occurs in **Sickness and Injury Benefits, Wellness and Screening Benefits**, and/or the **Miscellaneous Benefits** by amendatory endorsement pursuant to any federal or state law or regulation.

The current table of premium rates upon which the **Initial Premium** and the **First Renewal Premium** were calculated for this **Certificate** may include scheduled increases in the amount of **Renewal Premium** based upon the future attained age of each **Insured**. To be eligible for a discounted or preferred premium rate each **Insured** may be required to complete a preferred health risk assessment upon enrollment and at renewal. Additionally, the current table of premium rates upon which the **Initial Premium** and **First Renewal Premium** were calculated and any subsequent table of premium rates upon which the **Renewal Premium** for any renewal period is to be calculated may be changed from time to time by **Us**. Accordingly, after expiration of the **Premium Rate Guarantee Period**, the amount of **Renewal Premium** may be increased for any renewal period based upon items a. through l. above as well as the following:

- a. a new attained age of any **Insured** reached prior to the first day of any renewal period,
- b. change by **Us** in the table of premium rates used to calculate the **First Renewal Premium**, and
- c. change by **Us** in the table of premium rates used to calculate **Renewal Premium** for any prior renewal period.

Any changes in the table of premium rates establishing the amount of required **Renewal Premium** during any renewal period will be implemented on a **Class** basis for all members of **Your Renewal Premium Class**. Factors that may be involved and considered by **Us** in determining the amount of **Renewal Premium** to be charged to **Your Renewal Premium Class** during any renewal period include, among other things, a combination of one or more of the following: (i) past claims experience of **Your Renewal Premium Class**; (ii) anticipated inflationary trends in the cost of future medical services; (iii) historical experience in the inflationary cost of medical services; (iv) anticipated inflationary trends in the cost of **Prescription Drugs**; (v) historical experience in the past inflationary cost of **Prescription Drugs**; (vi) anticipated future claims experience of **Your Renewal Premium Class**; (vii) other economic factors; (viii) anticipated advances in the medical diagnosis capabilities of injuries and illnesses, including the anticipated cost thereof; (ix) anticipated advances in the manner, method and delivery of medical care and treatment, including the anticipated cost thereof; and (x) any other reason permitted by applicable state law. **We** will tell **You** at least [thirty (30)] days in advance of the effective date of any **Renewal Premium** increase that occurs due to a change in the table of premium rates for **Renewal Premium**.

## 2. RENEWAL PREMIUM CHECK OR DRAFT NOT HONORED

Any premium payment made by a check or draft which is not honored at the bank upon which it is drawn shall be of no effect toward coverage under this **Certificate** unless and until valid restitution is made to **Us** within the time provided herein for making such premium payment.

## 3. GRACE PERIOD

Unless at least thirty-one (31) days prior to a **Renewal Premium** due date **We** have mailed to **You** written notice of **Our** intention not to renew this **Certificate** pursuant to the provisions of Section III. C. TERMINATION OF COVERAGE, a grace period of thirty-one (31) days from such due date is given for the late payment of the **Renewal Premium** due. If **You** make payment of the required **Renewal Premium** during such grace period, then this **Certificate** will remain in force for **Benefit** claims arising during such grace period. However, if the **Company** has received notification of **Your** intention to cancel any **Insured's** coverage under this **Certificate**, there is no grace period for the late payment of any **Renewal Premium** that would otherwise have been due for such **Insured** but for such cancellation.

#### 4. REINSTATEMENT

If the **Renewal Premium** is not paid before the grace period ends, later acceptance of premium by **Us** (or by an agent authorized to accept payment) without requiring an application for reinstatement will reinstate this **Certificate** as of the date of acceptance of the late premium. If **We** require an application that will be fully underwritten by **Us**, **You** will be given a conditional receipt for the premium. If the application is approved after underwriting, this **Certificate** will be reinstated as of the approval date together with all back or past due premium permitted by applicable state law. Lacking such approval, this **Certificate** will be reinstated on the forty-fifth (45<sup>th</sup>) day after the date of the conditional receipt, unless **We** have previously notified **You**, in writing, of **Our** disapproval of the reinstatement.

The reinstated **Certificate** will cover only **Covered Expenses** that result from an **Injury** sustained after the date of reinstatement or from **Sickness** that begins more than ten (10) days after the date of reinstatement.

In all other respects **Your** rights and **Our** rights will remain the same subject to any provisions noted on or attached to the reinstated **Certificate**.

#### 5. PREMIUM RATE GUARANTEE PERIOD

The amount of **Renewal Premium** with the same **Mode of Premium Payment** as the **Mode of Premium Payment** of the **Initial Premium** is guaranteed not to exceed the amount of the **Initial Premium** for each renewal period commencing prior to the expiration of the **Premium Rate Guarantee Period** as a result of any: (i) change in the table of premium rates used to calculate the **Initial Premium**; or (ii) increase in the attained age after the **Issue Date** of any **Insured** listed on the **Certificate Schedule**. The length of the **Premium Rate Guarantee Period** is shown on the **Certificate Schedule**. However, **Renewal Premium** rates may be increased by **Us** for any renewal period after the **Issue Date**, including during the **Premium Rate Guarantee Period**, if after the **Issue Date** (i) **You** either add or change coverage under this **Certificate** as provided in paragraphs a. through l. of the Calculation – Payment provision, or (ii) an amendatory endorsement is issued that changes any of the **Benefits** pursuant to any federal or state law or regulation.

This Amendatory Endorsement is subject to all the terms, conditions, limitations, exclusions and definitions of the **Certificate** to which it is attached not inconsistent herewith. In all other aspects **Your** coverage remains the same.

  
SECRETARY

  
PRESIDENT

**AGENT INFORMATION**

Agent Name (print name): \_\_\_\_\_ Agent Number: \_\_\_\_\_

**TYPE OF ACTIVITY**

<input type="checkbox"/> New Application	<input type="checkbox"/> Exchange Application	<input type="checkbox"/> Addition/Changes to Existing Coverage
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**APPLICANT INFORMATION**

	<i>First</i>	Name <i>M.I.</i>	<i>Last</i>	Sex	Age	Birth date (MM/DD/YY)	Birthplace	Height	Weight	Social Security Number
1. Primary										
2. Spouse										
3a. Dependent(s)										
3b.										
3c.										
3d.										
3e.										
3f.										
3g.										

**RESIDENT ADDRESS**

4a. Address:		4c. Home Phone:	(      )
City:		4d. Business Phone:	(      )
State:	Zip Code:	4e. Cell Phone:	(      )
4b. Email:		4f. Best time to call:	

 May we send you communications via this email address?  Yes  No

**OCCUPATION INFORMATION**

5a. Primary Applicant's Employer:		Occupation/Duties:	
5b. Spouse's Employer:		Occupation/Duties:	

**BENEFICIARY DESIGNATION**

6a. Primary's Beneficiary:	6b. Spouse's Beneficiary:
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**TOBACCO INFORMATION**

Any form of tobacco or tobacco cessation product in past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes", which applicant? <input type="checkbox"/> Primary applicant <input type="checkbox"/> Spouse	

**REQUESTED EFFECTIVE DATE**

This effective date request does not guarantee that the application will be approved before the requested date, and thus may not be honored.

Specific Date / /

On the next \_\_\_\_\_ (except 29<sup>th</sup>, 30<sup>th</sup>, or 31<sup>st</sup> of the month after underwriting decision.)

Date of Application Approval

**COVERAGE SELECTION****PPO Network:****Preferred:**

Are any proposed applicant(s) listed applying for preferred rates?  Yes  No If Yes, which applicant?  Primary applicant  Spouse

Are any proposed applicant(s) listed applying for preferred smoker rates?  Yes  No If Yes, which applicant?  Primary applicant  Spouse

**Premium Rate Guarantee Period:**

12 Months  
(Not available on MedSecure)

18 Months  
(Available on MedEssential, MedEssential HSA, and MedSaver HSA)

24 Months  
(not available on MedSaver plans)

36 Months  
(not available on MedSaver, MedSecure, or MedAdvantage plans)

48 months  
(not available on MedSaver or MedAdvantage plans)

**Method of Payment:**

Bank Draft

Direct Billing  
(must submit payment)

Credit Card  
(initial payment only)

**Mode of Payment:**

Monthly

Quarterly

Semi-Annual

Annual

**Lifetime Maximum:**

\$1,000,000  
(MedSaver Plans Only)

\$2,000,000

\$5,000,000

**Organ Transplant Maximum:**

\$250,000  
(MedSaver Plans Only)

\$500,000

\$1,000,000

**PLAN SELECTION** **MedEquity HSA Plan** **MedSaver HSA Plus Plan**

Individual ded  \$1,200 (80% and 50% plan only)  \$2,000  \$2,700  \$3,500  \$5,000 (100% plan only)

Family ded  \$2,400 (80% and 50% plan only)  \$4,000  \$5,400  \$7,000  \$10,000 (100% plan only)

**Coinsurance Options**

PPO 100% Non-PPO 80%

PPO 80% Non-PPO 60%

PPO 50% Non-PPO 50%

**Optional Riders**

Waiver of Premium Rider (Not available on MedSaver Plans)

Other \_\_\_\_\_

 **MedEssential HSA Plan** **MedSaver HSA Plan**

Individual ded  \$1,200 (70% and 50% plan only)  \$2,000  \$2,700  \$3,500  \$5,000 (100% plan only)

Family ded  \$2,400 (70% and 50% plan only)  \$4,000  \$5,400  \$7,000  \$10,000 (100% plan only)

**Coinsurance Options**

PPO 100% Non-PPO 80%

PPO 70% Non-PPO 50%

PPO 50% Non-PPO 50%

**Optional Riders**

Waiver of Premium Rider (Not available on MedSaver Plans)

Radiation/Chemotherapy Rider

Other \_\_\_\_\_

**Calendar Year Maximum Benefit Per Insured for Outpatient Treatment**

\$5,000  \$10,000  \$15,000  \$25,000

(The \$5,000 maximum is not available on deductibles of \$3,500, \$5,000, \$7,000 or \$10,000)

**Calendar Year Maximum Per Insured for Outpatient Prescription Drugs**

\$2,000  Calendar Year Maximum Per Insured for Outpatient Treatment

**PLAN SELECTION (Cont.)**

**MedAdvantage Plan**

*Deductible*     \$15,000     \$20,000     \$25,000     \$50,000

**Coinsurance Options**

PPO 100%    Non-PPO 80%

**Optional Riders**

Waiver of Premium Rider

Other \_\_\_\_\_

**MedComplete Plan**

**MedSaver Complete Plan**

*Deductible*     \$1,000     \$1,500     \$2,000     \$2,500     \$3,000     \$4,000     \$5,000     \$10,000

**Coinsurance Options**

PPO 80% to \$10,000/Non-PPO 60% to \$10,000

PPO 50% to \$5,000/Non-PPO 50% to \$15,000

PPO 50% to \$10,000/Non-PPO 50% to \$20,000

**Optional Riders**

Waiver of Premium Rider *(Not available on MedSaver Plans)*

Dr. Office Co-Pay Rider *(Only available with deductibles of \$1,000, \$1,500, \$2,000 and \$2,500)*

Other \_\_\_\_\_

**MedEssential Plan**

*Deductible*     \$1,200     \$1,700     \$2,500

**Coinsurance Options**

PPO 70%    Non-PPO 50%

PPO 50%    Non-PPO 50%

**Optional Riders**

Waiver of Premium Rider

Dr. Office Co-Pay Rider

Radiation/Chemotherapy Rider

Other \_\_\_\_\_

**Calendar Year Maximum Benefit Per Insured/Calendar Year Maximum per Insured for Outpatient Treatment**

\$50,000 / \$2,500     \$100,000 / \$2,500     \$100,000 / \$5,000     \$250,000 / \$5,000     \$250,000 / \$10,000

**Calendar Year Maximum Per Insured for Outpatient Prescription Drugs**

\$2,000     Calendar Year Maximum Per Insured for Outpatient Treatment

**MedSecure Plan**

*Deductible*     \$2,000 (48 month rate guarantee only)     \$3,000 (48 month rate guarantee only)     \$5,000 (48 month rate guarantee only)  
 \$7,500 (24 month rate guarantee only)     \$10,000 (24 month rate guarantee only)

**Coinsurance Options**

PPO 70%    Non-PPO 30%

**Optional Riders**

Waiver of Premium Rider

Other \_\_\_\_\_

**Other Product** \_\_\_\_\_

*Deductible* \_\_\_\_\_

**Optional Riders**

*Coinsurance Option* \_\_\_\_\_

*Other* \_\_\_\_\_

**Total Primary Plan Premium** \$ \_\_\_\_\_

\*\*\*\*THIS AREA IS INTENDED FOR EXPANSION OF PLAN SELECTION IF NEEDED\*\*\*\*

**PREMIUM ADJUSTMENTS**

Rate Ups:	<input type="checkbox"/> Primary Applicant	_____ % for	<input type="checkbox"/> HBP
		_____ % for	<input type="checkbox"/> HT/WT
	<input type="checkbox"/> Spouse	_____ % for	<input type="checkbox"/> HBP
		_____ % for	<input type="checkbox"/> HT/WT
Rate Up Total \$ _____			

**OTHER COVERAGE PLANS**

<input type="checkbox"/> <b>MedGuard – Critical Illness</b>							
<input type="checkbox"/> Primary Applicant - Money Purchase plan	<input type="checkbox"/> \$20	<input type="checkbox"/> \$30	<input type="checkbox"/> \$40	<input type="checkbox"/> \$50	<input type="checkbox"/> \$60	<input type="checkbox"/> \$80	
<input type="checkbox"/> Spouse- Money Purchase plan	<input type="checkbox"/> \$20	<input type="checkbox"/> \$30	<input type="checkbox"/> \$40	<input type="checkbox"/> \$50	<input type="checkbox"/> \$60	<input type="checkbox"/> \$80	
<input type="checkbox"/> Child Benefit	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$15,000	Amount: \$ _____	Total MedGuard Premium \$ _____		
<input type="checkbox"/> <b>Life Protector</b>							
<input type="checkbox"/> Primary Applicant - Money Purchase plan	<input type="checkbox"/> \$20	<input type="checkbox"/> \$30	<input type="checkbox"/> \$40	<input type="checkbox"/> \$50			
Primary Applicant Death Benefit	\$ _____						
<input type="checkbox"/> Spouse- Money Purchase plan	<input type="checkbox"/> \$20	<input type="checkbox"/> \$30	<input type="checkbox"/> \$40	<input type="checkbox"/> \$50			
Spouse Death Benefit	\$ _____						
				Total Life Protector Premium \$ _____			
<input type="checkbox"/> <b>Dental Expense</b>							
<input type="checkbox"/> Primary Applicant	<input type="checkbox"/> Spouse	<input type="checkbox"/> Dependents (List names) _____				Total Dental Premium \$ _____	
						Total Monthly Premium \$ _____	

**ASSOCIATION INFORMATION**

Name of Association _____	Monthly Membership Dues \$ _____
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**PAYMENTS**

Monthly Payment \$ _____
Association One Time Initiation Fee \$ _____
Total with Application \$ _____

\*\*\*\*THIS AREA IS INTENDED FOR EXPANSION OF PLAN SELECTION IF NEEDED\*\*\*\*

**CURRENT AND PRIOR COVERAGE**

7. Does any applicant(s) currently have, or has any applicant made application for any type of health insurance?  Yes  No

If "Yes", complete the section below for all applicant's covered:

Applicant's Name	Insurance Company Name	Individual/Group	Type Coverage	Date Effective	Date Terminated

8. Are all applicant(s) covered under the current/prior coverage listed above?  Yes  No

If "No", list those not covered \_\_\_\_\_

9. Is the coverage you are applying for intended to replace your existing coverage?  Yes  No

**If Yes, please be advised that you should not cancel your current coverage until you receive and review your certificate/policy, if issued.**

10. Has any applicant ever been declined, had coverage excluded, been charged extra premium, or been postponed for any kind of personal insurance, or in the past 18 months filed a claim for disability, or are you or any member listed receiving benefits from Social Security or Workers' Compensation?  Yes  No

If "Yes", provide details: \_\_\_\_\_

**MEDICAL HISTORY**

**IMPORTANT! PLEASE GIVE COMPLETE DETAILS OF EACH "YES" ANSWER ON THE "ADDITIONAL MEDICAL DETAILS" PAGE.**

11. In the last 10 years, has any applicant been diagnosed with, treated for, taken medications for, consulted with, had symptoms of, or been advised to seek treatment for any disease or disorder of the:

- a) lungs or respiratory system including but not limited to asthma, allergies, pneumonia, chronic bronchitis, emphysema, tuberculosis, chronic obstructive pulmonary disease (COPD) or sleep apnea?  Yes  No
- b) heart or circulatory system including but not limited to high blood pressure, coronary artery disease, heart attack, heart murmur, congestive heart failure, mitral valve prolapse, irregular heartbeat, stroke, transient ischemic attack (TIA), or aneurysm?  Yes  No
- c) blood or blood forming organs including but not limited to anemia, hemophilia, or blood clots?  Yes  No
- d) stomach, esophagus, irritable bowel disease (IBS), gastro-reflux, intestines, rectum, or digestive system including but not limited to ulcers, colitis, gastritis, crohn's disease, hernia, hemorrhoids, or gallbladder disease?  Yes  No
- e) liver including but not limited to abnormal liver function tests, hepatitis, or cirrhosis?  Yes  No
- f) kidneys or urinary system including but not limited to kidney stones, urinary tract infections, cystitis, or urinary incontinence?  Yes  No
- g) pancreas including but not limited diabetes, or sugar/glucose intolerance, or pancreatitis?  Yes  No
- h) thyroid, pituitary, adrenal or endocrine glands including but not limited to hyperthyroidism, Graves' disease, or goiter?  Yes  No
- i) neuromuscular system including but not limited to Parkinson's disease, muscular dystrophy, or Lou Gehrig's disease/ALS?  Yes  No
- j) bones, muscles, joints, or connective tissues including but not limited to knees, shoulders, rheumatism, arthritis, rheumatoid arthritis, gout, fibromyalgia, temporomandibular joint disorder, (TMJ), carpal tunnel syndrome, lupus or lyme disease?  Yes  No
- k) back, neck or spine including but not limited to sprain or strain, herniated or slipped disc, chiropractic adjustments, spinal manipulations, or developmental disorder of the back?  Yes  No
- l) brain or central nervous system including but not limited to convulsions, epilepsy, seizures, recurrent headaches, migraine(s), head injuries, dementia, alzheimer's, multiple sclerosis, paralysis, cerebral palsy, or restless leg syndrome (RLS)?  Yes  No
- m) skin including but not limited to skin cancer, psoriasis, eczema, or skin lesions?  Yes  No
- n) eyes, ears, nose or throat including but not limited to glaucoma, cataracts, blindness, tubes in ears, deafness or hearing loss, cochlear Implants, chronic tonsillitis or deviated septum?  Yes  No
- o) **Male Applicant(s)** – breast, prostate, or male reproductive system including but not limited to an abnormal PSA test or impotence?  Yes  No
- p) 1. **Female Applicant(s)** - breast or female reproductive system including but not limited to endometriosis, pelvic pain, menstruation disorder, cyst or fibroid tumors?  Yes  No
- 2. Date of last PAP Smear test: \_\_\_\_\_ Results: \_\_\_\_\_
- 3. Have you been advised or instructed to have a repeat PAP Smear test or advised to have any follow-up treatment or test as a result of your PAP Smear test?  Yes  No

**MEDICAL HISTORY (Cont.)**

- q) Is any applicant listed currently pregnant, or expecting a child with anyone, whether or not listed on this application, or in the process of adoption?  Yes  No
12. In the last 10 years, has any applicant :
- a) received consultation, testing, or counseling for infertility, impotence, in-vitro fertilization, artificial insemination, or surrogacy?  Yes  No
  - b) been treated for sexually transmitted disease, hormone imbalance or oral contraceptive reaction of any kind?  Yes  No
  - c) tested positive for the presence of the HIV infection, or been diagnosed as having acquired immune deficiency syndrome (AIDS), or AIDS related complex (ARC)?  Yes  No
  - d) had or is any applicant considering any cosmetic or reconstructive surgery, or has any applicant ever had or been diagnosed or treated for a congenital birth defect or bodily deformity, or had or considering an organ donation or transplant?  Yes  No
  - e) had or does any applicant have a monitoring device, implants, amputation(s), prosthetic, or internal fixations (i.e. pins, plates, screws, shunt, pacemaker), or been advised to use a walking aid, wheelchair, or any other device or equipment?  Yes  No
  - f) had leukemia, hodgkin's disease, lymphoma or any other form of cancer?  Yes  No
  - g) had a tumor, cyst or any form of growth?  Yes  No
  - h) had any form of eating disorder, or surgery for weight control?  Yes  No
  - i) had mental, emotional or nervous disease or disorder including but not limited to depression, anxiety, bipolar disorder, mental retardation, eating disorder, learning/behavior/developmental disorder, attention deficit disorder or ADHD, or psychiatric treatment or counseling?  Yes  No
  - j) been advised or treated for alcohol or drug abuse, used illegal drugs, been a member of any alcohol or drug support group, or been given counseling or directive to seek treatment for use or abuse of alcohol or drugs?  Yes  No
13. Has any applicant been recommended or scheduled for a diagnostic test, medical treatment, surgery or therapy which has not yet been performed?  Yes  No
14. In the past five years, has any applicant gone to any health care professional for diagnosis, advice, treatment, checkup or consultation, treated in an Emergency room or been confined to a hospital, clinic, or other medical facility for any condition, disease or disorder not listed above?  Yes  No
15. (If requesting Life Protector or MedGuard coverage) Has any person proposed for coverage had an immediate family member diagnosed with heart disease, heart attack, stroke, kidney disorder, diabetes, cancer, leukemia, or Hodgkin's Disease? (An immediate family member is a father, mother, brother or sister.)  Yes  No

16. Please list all drugs prescribed or taken in the past 12 months.			
Applicant:	RX/Med:	Reason:	Doctor:

**OTHER PHYSICIANS**

17. Regular physician or medical practitioner for each proposed insured. If none, provide last physician seen, date, reason and results.
- Primary Applicant's Physician \_\_\_\_\_  
 Address \_\_\_\_\_  
 Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_
- Spouse's Physician \_\_\_\_\_  
 Address \_\_\_\_\_  
 Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_
- Dependent's Name \_\_\_\_\_ Physician \_\_\_\_\_  
 Address \_\_\_\_\_  
 Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_
- Dependent's Name \_\_\_\_\_ Physician \_\_\_\_\_  
 Address \_\_\_\_\_  
 Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_
- Dependent's Name \_\_\_\_\_ Physician \_\_\_\_\_  
 Address \_\_\_\_\_  
 Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_



**ADDITIONAL QUESTIONS**

19. Has any applicant been cited for a DWI or DUI or had their driver's license suspended or revoked in the past 5 years, or currently on probation or been convicted of a felony in the past 10 years?  Yes  No  
If "Yes", provide details: \_\_\_\_\_
20. Are all applicants U.S. Citizen(s) or do all applicants have Permanent Residence status (Green Card)?  Yes  No
21. Do any applicants participate in any hazardous avocation or sport including but not limited to vehicle racing, skydiving, pilot or student pilot, scuba diving, rock or mountain climbing, or rodeo?  Yes  No  
If "Yes", provide details: \_\_\_\_\_
22. Has any applicant traveled outside the U.S. for more than 30 days in the past two years, or does any applicant plan to travel outside the U.S. for more than 30 days in the next two years?  Yes  No  
If "Yes", provide details: \_\_\_\_\_

**FRAUD NOTICE**

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**RELEASE OF INFORMATION NOTICE:**

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life and health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Brain Tree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Company or its reinsurers, may also release information from its file to other insurance companies to whom you apply for life or health insurance, or to whom a claim of benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

**CONSUMER REPORT NOTICE:**

This is to inform you as part of our procedure for processing your application an investigative report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of the investigation.

**APPLICANT'S ACKNOWLEDGMENTS AND AUTHORIZATIONS**

By signing below I understand, certify and agree that:

- The health insurance coverage that I am applying for is not designated nor intended to be a health insurance plan that is employer provided.
- I am applying as an individual and the company will individually evaluate and underwrite my application.
- No part of the premiums or benefits are paid by my employer, nor will I be reimbursed through wage adjustment or otherwise for any portion of the premium to be charged.
- The insurance coverage I am applying for shall not be treated by an employer as a part of a plan or program for the purpose of section 162, 106, or section 125 of the Internal Revenue Code.
- Freedom Life Insurance Company of America will confirm the information provided on this application for insurance with a verification telephone call. This verification call is a routine process for those applying for coverage with Freedom Life Insurance Company of America and that this telephone call will be recorded. I also understand that my application will not be considered if verification is not completed. I (or my spouse, if applicable) may be contacted at the telephone numbers listed on the first page. If I cannot be contacted, I will call Freedom Life Insurance Company of America at 1-800-387-9027.
- I hereby apply to Freedom Life Insurance Company of America for insurance coverage to be issued in reliance upon the answers made to the best of my knowledge and belief and agree that the answers are full, true and complete in their entirety. I agree that the information and answers given shall form the basis for and be a part of any insurance under which coverage is issued. The coverage shall not be effective until a Certificate/Policy has been actually issued and delivered to the Insured, with first premium paid while the health of all persons named in this Application remains as stated therein.
- The agent is not an officer of the Company and cannot change, alter or amend the Group Policy, the application, the Certificate, Individual Policy or any information requirement of the Company. I further understand that the agent has no authority to make any representations about the conditions under which the Company will issue a Certificate/Policy or make coverage under the Certificate/Policy effective.
- If coverage is offered that it shall be subject to the timely payment by me and receipt by the Company of the Initial Premium amount and Certificate/Policy administration fees. Should payment of such Initial Premium and fees not be timely made and received or returned for insufficiency of funds or in any other way insufficient or not honored, I understand, acknowledge and agree that the corresponding offer of coverage is withdrawn, void and of no effect.
- I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has records or knowledge of me, or any member of my family who is to be insured, to give to Freedom Life Insurance Company of America or its reinsurer any such information. To facilitate rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give all such records or knowledge to any agency employed by Freedom Life Insurance Company of America to collect and transmit such information. I authorize Freedom Life Insurance Company of America to use such information to make determinations regarding enrollment, underwriting, eligibility of benefits, or any other healthcare operations related to the consumer as a prospective insured or as an insured with Freedom Life Insurance Company of America. A photographic or electronic copy of this authorization shall be as valid as the original. This authorization shall be valid for two years from the date signed. I hereby acknowledge receipt of the Medical Information Bureau (MIB), the Notice of Information Practices and Privacy Policy, and the Fair Credit Reporting Act (FCRA) notice.
- My/our answers to the questions and the information provided in application are complete, accurate and true to the best of my/our knowledge and belief. I understand and acknowledge that any fraudulent statement or material misrepresentation on the application and/or amendments may result in claim denial or contract rescission. I further understand that losses due to Pre-existing Conditions, diseases or bodily injuries occurring prior to the effective date of coverage are not covered, subject to Certificate/Policy provisions, unless otherwise provided.

**Attention Applicant:** I hereby certify and affirm that my/our responses to the questions contained on this application are complete, accurate and true to the best of my/our knowledge and belief, I understand and acknowledge that any fraudulent statement of material misrepresentation on the application and/or amendments may result in claim denial or contract rescission. I further understand that losses due to Pre-existing Conditions, diseases or bodily injuries occurring prior to the effective date of coverage are not covered, subject to the Certificate/Policy provisions, unless otherwise provided. If your electronic signature cannot be provided, your verbal electronic signature will be obtained during a recorded telephone interview before coverage will be considered.

Dated at \_\_\_\_\_  
(City) (State) (Month) (Day) (Year)

✕ \_\_\_\_\_  
Signature of Applicant

✕ \_\_\_\_\_  
Signature of Spouse, if Applicable

I certify that I have truly and accurately recorded on the application form the information supplied by the applicant and that I am not aware of any other information that might have an adverse effect on the insurability of any person here proposed for insurance.

I certify that I have reviewed this application, and that it has been completed in full for submission to Freedom Life Insurance Company of America.

Agent's Signature \_\_\_\_\_ Agent # \_\_\_\_\_ Date: \_\_\_\_\_

*SERFF Tracking Number:*      *USHG-126148077*                      *State:*                      *Arkansas*  
*Filing Company:*              *Freedom Life Insurance Company of America*      *State Tracking Number:*      *42363*  
*Company Tracking Number:*      *PPO RATE-AE-09-FLIC*  
*TOI:*                      *H16G Group Health - Major Medical*              *Sub-TOI:*                      *H16G.002A Large Group Only - PPO*  
*Product Name:*              *PPO-RATE-AE-FLIC*  
*Project Name/Number:*      /

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: USHG-126148077 State: Arkansas  
Filing Company: Freedom Life Insurance Company of America State Tracking Number: 42363  
Company Tracking Number: PPO RATE-AE-09-FLIC  
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.002A Large Group Only - PPO  
Product Name: PPO-RATE-AE-FLIC  
Project Name/Number: /

## Supporting Document Schedules

**Satisfied -Name:** Flesch Certification **Review Status:** Approved-Closed 05/18/2009  
**Comments:**  
**Attachment:**  
PPO-RATE-AE-09-FLIC FLESCH.pdf

**Satisfied -Name:** Application **Review Status:** Approved-Closed 05/18/2009  
**Comments:**  
**Attachment:**  
APP-09-FLIC - noarb.pdf

FREEDOM LIFE INSURANCE COMPANY OF AMERICA

[3100 Burnett Plaza 801 Cherry Street, Unit 33 Fort Worth, Texas 76102 1-800-387-9027]

READABILITY CERTIFICATION

I hereby certify that the forms, listed below, have been properly scored and have achieved the Flesch Score, as indicated.

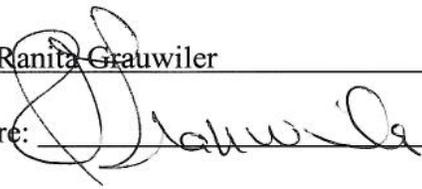
Form Number

Flesch Score

PPO-RATE-AE-09-FLIC

53.429

Name: Ranita Grauwiler

Signature: 

Title: Vice President, Product Development / Administration

Dated: April 27, 2009

**AGENT INFORMATION**

Agent Name (print name): \_\_\_\_\_ Agent Number: \_\_\_\_\_

**TYPE OF ACTIVITY**

<input type="checkbox"/> New Application	<input type="checkbox"/> Exchange Application	<input type="checkbox"/> Addition/Changes to Existing Coverage
--	---	--

**APPLICANT INFORMATION**

	<i>First</i>	Name <i>M.I.</i>	<i>Last</i>	Sex	Age	Birth date (MM/DD/YY)	Birthplace	Height	Weight	Social Security Number
1. Primary										
2. Spouse										
3a. Dependent(s)										
3b.										
3c.										
3d.										
3e.										
3f.										
3g.										

**RESIDENT ADDRESS**

4a. Address:		4c. Home Phone:	(      )
City:		4d. Business Phone:	(      )
State:	Zip Code:	4e. Cell Phone:	(      )
4b. Email:		4f. Best time to call:	

 May we send you communications via this email address?  Yes  No

**OCCUPATION INFORMATION**

5a. Primary Applicant's Employer:		Occupation/Duties:	
5b. Spouse's Employer:		Occupation/Duties:	

**BENEFICIARY DESIGNATION**

6a. Primary's Beneficiary:	6b. Spouse's Beneficiary:
----------------------------	---------------------------

**TOBACCO INFORMATION**

Any form of tobacco or tobacco cessation product in past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes", which applicant? <input type="checkbox"/> Primary applicant <input type="checkbox"/> Spouse	

**REQUESTED EFFECTIVE DATE**

This effective date request does not guarantee that the application will be approved before the requested date, and thus may not be honored.

Specific Date / /

On the next \_\_\_\_\_ (except 29<sup>th</sup>, 30<sup>th</sup>, or 31<sup>st</sup> of the month after underwriting decision.)

Date of Application Approval

**COVERAGE SELECTION****PPO Network:****Preferred:**

Are any proposed applicant(s) listed applying for preferred rates?  Yes  No If Yes, which applicant?  Primary applicant  Spouse

Are any proposed applicant(s) listed applying for preferred smoker rates?  Yes  No If Yes, which applicant?  Primary applicant  Spouse

**Premium Rate Guarantee Period:**

12 Months  
(Not available on MedSecure)

18 Months  
(Available on MedEssential, MedEssential HSA, and MedSaver HSA)

24 Months  
(not available on MedSaver plans)

36 Months  
(not available on MedSaver, MedSecure, or MedAdvantage plans)

48 months  
(not available on MedSaver or MedAdvantage plans)

**Method of Payment:**

Bank Draft

Direct Billing  
(must submit payment)

Credit Card  
(initial payment only)

**Mode of Payment:**

Monthly

Quarterly

Semi-Annual

Annual

**Lifetime Maximum:**

\$1,000,000  
(MedSaver Plans Only)

\$2,000,000

\$5,000,000

**Organ Transplant Maximum:**

\$250,000  
(MedSaver Plans Only)

\$500,000

\$1,000,000

**PLAN SELECTION** **MedEquity HSA Plan** **MedSaver HSA Plus Plan**

Individual ded  \$1,200 (80% and 50% plan only)  \$2,000  \$2,700  \$3,500  \$5,000 (100% plan only)

Family ded  \$2,400 (80% and 50% plan only)  \$4,000  \$5,400  \$7,000  \$10,000 (100% plan only)

**Coinsurance Options**

PPO 100% Non-PPO 80%

PPO 80% Non-PPO 60%

PPO 50% Non-PPO 50%

**Optional Riders**

Waiver of Premium Rider (Not available on MedSaver Plans)

Other \_\_\_\_\_

 **MedEssential HSA Plan** **MedSaver HSA Plan**

Individual ded  \$1,200 (70% and 50% plan only)  \$2,000  \$2,700  \$3,500  \$5,000 (100% plan only)

Family ded  \$2,400 (70% and 50% plan only)  \$4,000  \$5,400  \$7,000  \$10,000 (100% plan only)

**Coinsurance Options**

PPO 100% Non-PPO 80%

PPO 70% Non-PPO 50%

PPO 50% Non-PPO 50%

**Optional Riders**

Waiver of Premium Rider (Not available on MedSaver Plans)

Radiation/Chemotherapy Rider

Other \_\_\_\_\_

**Calendar Year Maximum Benefit Per Insured for Outpatient Treatment**

\$5,000  \$10,000  \$15,000  \$25,000

(The \$5,000 maximum is not available on deductibles of \$3,500, \$5,000, \$7,000 or \$10,000)

**Calendar Year Maximum Per Insured for Outpatient Prescription Drugs**

\$2,000  Calendar Year Maximum Per Insured for Outpatient Treatment

**PLAN SELECTION (Cont.)**

**MedAdvantage Plan**

*Deductible*     \$15,000     \$20,000     \$25,000     \$50,000

**Coinsurance Options**

PPO 100%    Non-PPO 80%

**Optional Riders**

Waiver of Premium Rider

Other \_\_\_\_\_

**MedComplete Plan**

**MedSaver Complete Plan**

*Deductible*     \$1,000     \$1,500     \$2,000     \$2,500     \$3,000     \$4,000     \$5,000     \$10,000

**Coinsurance Options**

PPO 80% to \$10,000/Non-PPO 60% to \$10,000

PPO 50% to \$5,000/Non-PPO 50% to \$15,000

PPO 50% to \$10,000/Non-PPO 50% to \$20,000

**Optional Riders**

Waiver of Premium Rider *(Not available on MedSaver Plans)*

Dr. Office Co-Pay Rider *(Only available with deductibles of \$1,000, \$1,500, \$2,000 and \$2,500)*

Other \_\_\_\_\_

**MedEssential Plan**

*Deductible*     \$1,200     \$1,700     \$2,500

**Coinsurance Options**

PPO 70%    Non-PPO 50%

PPO 50%    Non-PPO 50%

**Optional Riders**

Waiver of Premium Rider

Dr. Office Co-Pay Rider

Radiation/Chemotherapy Rider

Other \_\_\_\_\_

**Calendar Year Maximum Benefit Per Insured/Calendar Year Maximum per Insured for Outpatient Treatment**

\$50,000 / \$2,500     \$100,000 / \$2,500     \$100,000 / \$5,000     \$250,000 / \$5,000     \$250,000 / \$10,000

**Calendar Year Maximum Per Insured for Outpatient Prescription Drugs**

\$2,000     Calendar Year Maximum Per Insured for Outpatient Treatment

**MedSecure Plan**

*Deductible*     \$2,000 (48 month rate guarantee only)     \$3,000 (48 month rate guarantee only)     \$5,000 (48 month rate guarantee only)  
 \$7,500 (24 month rate guarantee only)     \$10,000 (24 month rate guarantee only)

**Coinsurance Options**

PPO 70%    Non-PPO 30%

**Optional Riders**

Waiver of Premium Rider

Other \_\_\_\_\_

**Other Product** \_\_\_\_\_

*Deductible* \_\_\_\_\_

**Optional Riders**

*Coinsurance Option* \_\_\_\_\_

*Other* \_\_\_\_\_

**Total Primary Plan Premium** \$ \_\_\_\_\_

\*\*\*\*THIS AREA IS INTENDED FOR EXPANSION OF PLAN SELECTION IF NEEDED\*\*\*\*

**PREMIUM ADJUSTMENTS**

Rate Ups:	<input type="checkbox"/> Primary Applicant	_____ % for	<input type="checkbox"/> HBP
		_____ % for	<input type="checkbox"/> HT/WT
	<input type="checkbox"/> Spouse	_____ % for	<input type="checkbox"/> HBP
		_____ % for	<input type="checkbox"/> HT/WT
Rate Up Total \$ _____			

**OTHER COVERAGE PLANS**

<input type="checkbox"/> <b>MedGuard – Critical Illness</b>								
<input type="checkbox"/> Primary Applicant - Money Purchase plan	<input type="checkbox"/> \$20	<input type="checkbox"/> \$30	<input type="checkbox"/> \$40	<input type="checkbox"/> \$50	<input type="checkbox"/> \$60	<input type="checkbox"/> \$80		
<input type="checkbox"/> Spouse- Money Purchase plan	<input type="checkbox"/> \$20	<input type="checkbox"/> \$30	<input type="checkbox"/> \$40	<input type="checkbox"/> \$50	<input type="checkbox"/> \$60	<input type="checkbox"/> \$80		
<input type="checkbox"/> Child Benefit	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$15,000	Amount: \$ _____	Total MedGuard Premium \$ _____			
<input type="checkbox"/> <b>Life Protector</b>								
<input type="checkbox"/> Primary Applicant - Money Purchase plan	<input type="checkbox"/> \$20	<input type="checkbox"/> \$30	<input type="checkbox"/> \$40	<input type="checkbox"/> \$50				
Primary Applicant Death Benefit	\$ _____							
<input type="checkbox"/> Spouse- Money Purchase plan	<input type="checkbox"/> \$20	<input type="checkbox"/> \$30	<input type="checkbox"/> \$40	<input type="checkbox"/> \$50				
Spouse Death Benefit	\$ _____							
					Total Life Protector Premium \$ _____			
<input type="checkbox"/> <b>Dental Expense</b>								
<input type="checkbox"/> Primary Applicant	<input type="checkbox"/> Spouse	<input type="checkbox"/> Dependents (List names) _____					Total Dental Premium \$ _____	
					Total Monthly Premium \$ _____			

**ASSOCIATION INFORMATION**

Name of Association _____	Monthly Membership Dues \$ _____
---------------------------	----------------------------------

**PAYMENTS**

Monthly Payment \$ _____
Association One Time Initiation Fee \$ _____
Total with Application \$ _____

\*\*\*\*THIS AREA IS INTENDED FOR EXPANSION OF PLAN SELECTION IF NEEDED\*\*\*\*

**CURRENT AND PRIOR COVERAGE**

7. Does any applicant(s) currently have, or has any applicant made application for any type of health insurance?  Yes  No

If "Yes", complete the section below for all applicant's covered:

Applicant's Name	Insurance Company Name	Individual/Group	Type Coverage	Date Effective	Date Terminated

8. Are all applicant(s) covered under the current/prior coverage listed above?  Yes  No

If "No", list those not covered \_\_\_\_\_

9. Is the coverage you are applying for intended to replace your existing coverage?  Yes  No

**If Yes, please be advised that you should not cancel your current coverage until you receive and review your certificate/policy, if issued.**

10. Has any applicant ever been declined, had coverage excluded, been charged extra premium, or been postponed for any kind of personal insurance, or in the past 18 months filed a claim for disability, or are you or any member listed receiving benefits from Social Security or Workers' Compensation?  Yes  No

If "Yes", provide details: \_\_\_\_\_

**MEDICAL HISTORY**

**IMPORTANT! PLEASE GIVE COMPLETE DETAILS OF EACH "YES" ANSWER ON THE "ADDITIONAL MEDICAL DETAILS" PAGE.**

11. In the last 10 years, has any applicant been diagnosed with, treated for, taken medications for, consulted with, had symptoms of, or been advised to seek treatment for any disease or disorder of the:

- a) lungs or respiratory system including but not limited to asthma, allergies, pneumonia, chronic bronchitis, emphysema, tuberculosis, chronic obstructive pulmonary disease (COPD) or sleep apnea?  Yes  No
- b) heart or circulatory system including but not limited to high blood pressure, coronary artery disease, heart attack, heart murmur, congestive heart failure, mitral valve prolapse, irregular heartbeat, stroke, transient ischemic attack (TIA), or aneurysm?  Yes  No
- c) blood or blood forming organs including but not limited to anemia, hemophilia, or blood clots?  Yes  No
- d) stomach, esophagus, irritable bowel disease (IBS), gastro-reflux, intestines, rectum, or digestive system including but not limited to ulcers, colitis, gastritis, crohn's disease, hernia, hemorrhoids, or gallbladder disease?  Yes  No
- e) liver including but not limited to abnormal liver function tests, hepatitis, or cirrhosis?  Yes  No
- f) kidneys or urinary system including but not limited to kidney stones, urinary tract infections, cystitis, or urinary incontinence?  Yes  No
- g) pancreas including but not limited diabetes, or sugar/glucose intolerance, or pancreatitis?  Yes  No
- h) thyroid, pituitary, adrenal or endocrine glands including but not limited to hyperthyroidism, Graves' disease, or goiter?  Yes  No
- i) neuromuscular system including but not limited to Parkinson's disease, muscular dystrophy, or Lou Gehrig's disease/ALS?  Yes  No
- j) bones, muscles, joints, or connective tissues including but not limited to knees, shoulders, rheumatism, arthritis, rheumatoid arthritis, gout, fibromyalgia, temporomandibular joint disorder, (TMJ), carpal tunnel syndrome, lupus or lyme disease?  Yes  No
- k) back, neck or spine including but not limited to sprain or strain, herniated or slipped disc, chiropractic adjustments, spinal manipulations, or developmental disorder of the back?  Yes  No
- l) brain or central nervous system including but not limited to convulsions, epilepsy, seizures, recurrent headaches, migraine(s), head injuries, dementia, alzheimer's, multiple sclerosis, paralysis, cerebral palsy, or restless leg syndrome (RLS)?  Yes  No
- m) skin including but not limited to skin cancer, psoriasis, eczema, or skin lesions?  Yes  No
- n) eyes, ears, nose or throat including but not limited to glaucoma, cataracts, blindness, tubes in ears, deafness or hearing loss, cochlear Implants, chronic tonsillitis or deviated septum?  Yes  No
- o) **Male Applicant(s)** – breast, prostate, or male reproductive system including but not limited to an abnormal PSA test or impotence?  Yes  No
- p) 1. **Female Applicant(s)** - breast or female reproductive system including but not limited to endometriosis, pelvic pain, menstruation disorder, cyst or fibroid tumors?  Yes  No
- 2. Date of last PAP Smear test: \_\_\_\_\_ Results: \_\_\_\_\_
- 3. Have you been advised or instructed to have a repeat PAP Smear test or advised to have any follow-up treatment or test as a result of your PAP Smear test?  Yes  No

**MEDICAL HISTORY (Cont.)**

- q) Is any applicant listed currently pregnant, or expecting a child with anyone, whether or not listed on this application, or in the process of adoption?  Yes  No
12. In the last 10 years, has any applicant :
- a) received consultation, testing, or counseling for infertility, impotence, in-vitro fertilization, artificial insemination, or surrogacy?  Yes  No
  - b) been treated for sexually transmitted disease, hormone imbalance or oral contraceptive reaction of any kind?  Yes  No
  - c) tested positive for the presence of the HIV infection, or been diagnosed as having acquired immune deficiency syndrome (AIDS), or AIDS related complex (ARC)?  Yes  No
  - d) had or is any applicant considering any cosmetic or reconstructive surgery, or has any applicant ever had or been diagnosed or treated for a congenital birth defect or bodily deformity, or had or considering an organ donation or transplant?  Yes  No
  - e) had or does any applicant have a monitoring device, implants, amputation(s), prosthetic, or internal fixations (i.e. pins, plates, screws, shunt, pacemaker), or been advised to use a walking aid, wheelchair, or any other device or equipment?  Yes  No
  - f) had leukemia, hodgkin's disease, lymphoma or any other form of cancer?  Yes  No
  - g) had a tumor, cyst or any form of growth?  Yes  No
  - h) had any form of eating disorder, or surgery for weight control?  Yes  No
  - i) had mental, emotional or nervous disease or disorder including but not limited to depression, anxiety, bipolar disorder, mental retardation, eating disorder, learning/behavior/developmental disorder, attention deficit disorder or ADHD, or psychiatric treatment or counseling?  Yes  No
  - j) been advised or treated for alcohol or drug abuse, used illegal drugs, been a member of any alcohol or drug support group, or been given counseling or directive to seek treatment for use or abuse of alcohol or drugs?  Yes  No
13. Has any applicant been recommended or scheduled for a diagnostic test, medical treatment, surgery or therapy which has not yet been performed?  Yes  No
14. In the past five years, has any applicant gone to any health care professional for diagnosis, advice, treatment, checkup or consultation, treated in an Emergency room or been confined to a hospital, clinic, or other medical facility for any condition, disease or disorder not listed above?  Yes  No
15. (If requesting Life Protector or MedGuard coverage) Has any person proposed for coverage had an immediate family member diagnosed with heart disease, heart attack, stroke, kidney disorder, diabetes, cancer, leukemia, or Hodgkin's Disease? (An immediate family member is a father, mother, brother or sister.)  Yes  No

16. Please list all drugs prescribed or taken in the past 12 months.			
Applicant:	RX/Med:	Reason:	Doctor:

**OTHER PHYSICIANS**

17. Regular physician or medical practitioner for each proposed insured. If none, provide last physician seen, date, reason and results.
- Primary Applicant's Physician \_\_\_\_\_  
 Address \_\_\_\_\_  
 Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_
- Spouse's Physician \_\_\_\_\_  
 Address \_\_\_\_\_  
 Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_
- Dependent's Name \_\_\_\_\_ Physician \_\_\_\_\_  
 Address \_\_\_\_\_  
 Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_
- Dependent's Name \_\_\_\_\_ Physician \_\_\_\_\_  
 Address \_\_\_\_\_  
 Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_
- Dependent's Name \_\_\_\_\_ Physician \_\_\_\_\_  
 Address \_\_\_\_\_  
 Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_



**ADDITIONAL QUESTIONS**

19. Has any applicant been cited for a DWI or DUI or had their driver's license suspended or revoked in the past 5 years, or currently on probation or been convicted of a felony in the past 10 years?  Yes  No  
If "Yes", provide details: \_\_\_\_\_
20. Are all applicants U.S. Citizen(s) or do all applicants have Permanent Residence status (Green Card)?  Yes  No
21. Do any applicants participate in any hazardous avocation or sport including but not limited to vehicle racing, skydiving, pilot or student pilot, scuba diving, rock or mountain climbing, or rodeo?  Yes  No  
If "Yes", provide details: \_\_\_\_\_
22. Has any applicant traveled outside the U.S. for more than 30 days in the past two years, or does any applicant plan to travel outside the U.S. for more than 30 days in the next two years?  Yes  No  
If "Yes", provide details: \_\_\_\_\_

**FRAUD NOTICE**

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**RELEASE OF INFORMATION NOTICE:**

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life and health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Brain Tree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Company or its reinsurers, may also release information from its file to other insurance companies to whom you apply for life or health insurance, or to whom a claim of benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

**CONSUMER REPORT NOTICE:**

This is to inform you as part of our procedure for processing your application an investigative report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of the investigation.

**APPLICANT'S ACKNOWLEDGMENTS AND AUTHORIZATIONS**

By signing below I understand, certify and agree that:

- The health insurance coverage that I am applying for is not designated nor intended to be a health insurance plan that is employer provided.
- I am applying as an individual and the company will individually evaluate and underwrite my application.
- No part of the premiums or benefits are paid by my employer, nor will I be reimbursed through wage adjustment or otherwise for any portion of the premium to be charged.
- The insurance coverage I am applying for shall not be treated by an employer as a part of a plan or program for the purpose of section 162, 106, or section 125 of the Internal Revenue Code.
- Freedom Life Insurance Company of America will confirm the information provided on this application for insurance with a verification telephone call. This verification call is a routine process for those applying for coverage with Freedom Life Insurance Company of America and that this telephone call will be recorded. I also understand that my application will not be considered if verification is not completed. I (or my spouse, if applicable) may be contacted at the telephone numbers listed on the first page. If I cannot be contacted, I will call Freedom Life Insurance Company of America at 1-800-387-9027.
- I hereby apply to Freedom Life Insurance Company of America for insurance coverage to be issued in reliance upon the answers made to the best of my knowledge and belief and agree that the answers are full, true and complete in their entirety. I agree that the information and answers given shall form the basis for and be a part of any insurance under which coverage is issued. The coverage shall not be effective until a Certificate/Policy has been actually issued and delivered to the Insured, with first premium paid while the health of all persons named in this Application remains as stated therein.
- The agent is not an officer of the Company and cannot change, alter or amend the Group Policy, the application, the Certificate, Individual Policy or any information requirement of the Company. I further understand that the agent has no authority to make any representations about the conditions under which the Company will issue a Certificate/Policy or make coverage under the Certificate/Policy effective.
- If coverage is offered that it shall be subject to the timely payment by me and receipt by the Company of the Initial Premium amount and Certificate/Policy administration fees. Should payment of such Initial Premium and fees not be timely made and received or returned for insufficiency of funds or in any other way insufficient or not honored, I understand, acknowledge and agree that the corresponding offer of coverage is withdrawn, void and of no effect.
- I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has records or knowledge of me, or any member of my family who is to be insured, to give to Freedom Life Insurance Company of America or its reinsurer any such information. To facilitate rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give all such records or knowledge to any agency employed by Freedom Life Insurance Company of America to collect and transmit such information. I authorize Freedom Life Insurance Company of America to use such information to make determinations regarding enrollment, underwriting, eligibility of benefits, or any other healthcare operations related to the consumer as a prospective insured or as an insured with Freedom Life Insurance Company of America. A photographic or electronic copy of this authorization shall be as valid as the original. This authorization shall be valid for two years from the date signed. I hereby acknowledge receipt of the Medical Information Bureau (MIB), the Notice of Information Practices and Privacy Policy, and the Fair Credit Reporting Act (FCRA) notice.
- My/our answers to the questions and the information provided in application are complete, accurate and true to the best of my/our knowledge and belief. I understand and acknowledge that any fraudulent statement or material misrepresentation on the application and/or amendments may result in claim denial or contract rescission. I further understand that losses due to Pre-existing Conditions, diseases or bodily injuries occurring prior to the effective date of coverage are not covered, subject to Certificate/Policy provisions, unless otherwise provided.

**Attention Applicant:** I hereby certify and affirm that my/our responses to the questions contained on this application are complete, accurate and true to the best of my/our knowledge and belief, I understand and acknowledge that any fraudulent statement of material misrepresentation on the application and/or amendments may result in claim denial or contract rescission. I further understand that losses due to Pre-existing Conditions, diseases or bodily injuries occurring prior to the effective date of coverage are not covered, subject to the Certificate/Policy provisions, unless otherwise provided. If your electronic signature cannot be provided, your verbal electronic signature will be obtained during a recorded telephone interview before coverage will be considered.

Dated at \_\_\_\_\_  
(City) (State) (Month) (Day) (Year)

✕ \_\_\_\_\_  
Signature of Applicant

✕ \_\_\_\_\_  
Signature of Spouse, if Applicable

I certify that I have truly and accurately recorded on the application form the information supplied by the applicant and that I am not aware of any other information that might have an adverse effect on the insurability of any person here proposed for insurance.

I certify that I have reviewed this application, and that it has been completed in full for submission to Freedom Life Insurance Company of America.

Agent's Signature \_\_\_\_\_ Agent # \_\_\_\_\_ Date: \_\_\_\_\_