

SERFF Tracking Number:	ASWX-126587080	State:	Arkansas
Filing Company:	John Alden Life Insurance Company	State Tracking Number:	45437
Company Tracking Number:	IHAR01143JAF02		
TOI:	H16G Group Health - Major Medical	Sub-TOI:	H16G.001C Any Size Group - Other
Product Name:	John Alden-Base Chassis		
Project Name/Number:	John Alden-Base Chassis/IH AR01143JAF02		

## Filing at a Glance

Company: John Alden Life Insurance Company

Product Name: John Alden-Base Chassis      SERFF Tr Num: ASWX-126587080 State: Arkansas  
 TOI: H16G Group Health - Major Medical      SERFF Status: Closed-Approved- State Tr Num: 45437  
 Closed

Sub-TOI: H16G.001C Any Size Group - Other      Co Tr Num: IHAR01143JAF02      State Status: FEES PAID  
 Filing Type: Form      Reviewer(s): Rosalind Minor  
 Author: SPI      Disposition Date: 04/20/2010  
 AssurantHealthandEmployeeBenef  
 Date Submitted: 04/15/2010      Disposition Status: Approved-  
 Closed

Implementation Date Requested: 05/13/2010

Implementation Date:

State Filing Description:

## General Information

Project Name: John Alden-Base Chassis  
 Project Number: IH AR01143JAF02  
 Requested Filing Mode: Review & Approval  
 Explanation for Combination/Other:  
 Submission Type: New Submission  
 Overall Rate Impact:  
 Filing Status Changed: 04/20/2010

Status of Filing in Domicile:  
 Date Approved in Domicile:  
 Domicile Status Comments:  
 Market Type:  
 Group Market Size:  
 Group Market Type:  
 Explanation for Other Group Market Type:  
 State Status Changed: 04/16/2010  
 Created By: SPI  
 AssurantHealthandEmployeeBenef  
 Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: SPI AssurantHealthandEmployeeBenef  
 Filing Description:

The above-referenced forms are submitted for your review and approval and, once approved, will replace, in their entirety, Forms JI-2300 (Rev. 2/2010), JI-2400 (Rev. 2/2010), and JI- 29500 (Rev. 2/2010), which were recently approved by the Department on February 17, 2010 under SERFF tracking number ASWX-126478650. The only differences between the previously approved forms and the current versions are:

1. To correct the reference to "Medical Information Bureau" with "MIB, Inc." on the Acceptance of Offer and Attestation (page 1) of Form JI-2500 (Rev. 4/2010);
2. To update "John Alden Insurance Company" with "John Alden Life Insurance Company" throughout all forms;

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3. To replace a "Time Insurance Company" reference with "John Alden Life Insurance Company" on the Acceptance of Offer and Attestation (page 1) of Form JI-2500 (Rev. 4/2010).

## Company and Contact

### Filing Contact Information

Christine Fleming, Senior Contract Compliance christine.fleming@assurant.com  
 Analyst  
 501 W. Michigan St. 414-299-1306 [Phone] 1306 [Ext]  
 Milwaukee, WI 53203 414-299-6168 [FAX]

### Filing Company Information

John Alden Life Insurance Company	CoCode: 65080	State of Domicile: Wisconsin
501 W. Michigan Street	Group Code: 19	Company Type:
Milwaukee, WI 53203	Group Name:	State ID Number:
(800) 800-1212 ext. [Phone]	FEIN Number: 41-0999752	

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$150.00  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
John Alden Life Insurance Company	\$150.00	04/15/2010	35697161

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/20/2010	04/20/2010

*SERFF Tracking Number:* ASWX-126587080      *State:* Arkansas  
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## **Disposition**

Disposition Date: 04/20/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: ASWX-126587080 State: Arkansas  
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	Application for Individual Medical Insurance	Approved-Closed	Yes
Form	Application for Individual Medical Insurance	Approved-Closed	Yes
Form	Application for Individual Medical Insurance	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number: JI-2300 (Rev. 4/2010)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	JI-2300 (Rev. 04/20/2010)	Application/Enrollment Form	Application for Individual Medical Insurance	Initial		0.000	JI-2300 (Rev_4_2010).PDF
Approved-Closed	JI-2400 (Rev. 04/20/2010)	Application/Enrollment Form	Application for Individual Medical Insurance	Initial		0.000	JI-2400 (Rev_4_2010).PDF
Approved-Closed	JI-2500 (Rev. 04/20/2010)	Application/Enrollment Form	Application for Individual Medical Insurance	Initial		0.000	JI-2500 (Rev_4_2010).PDF

# Enrollment Form for Medical Insurance for Individuals and Families

## AGENT/AGENCY INFORMATION

Agent Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Agent Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
 Key Agency Contact: \_\_\_\_\_ Agency Name: \_\_\_\_\_  
 Fax Number: \_\_\_\_\_ Agency Number: \_\_\_\_\_  
 Sales Representative Number: \_\_\_\_\_

## TYPE OF ACTIVITY *(Please check appropriate box.)*

**NEW** *If not a new enrollee, check appropriate box and list affected policy number.*

<input type="checkbox"/> <b>CHANGE/ADDITION TO AN EXISTING POLICY. POLICY #</b> _____	
<input type="checkbox"/> Internal Replacement	<input type="checkbox"/> Removal/Reduction of Special Class Premium
<input type="checkbox"/> Adding Dependent	<input type="checkbox"/> Conversion (over age dependent/divorce)
<input type="checkbox"/> Removal of Tobacco Rates	<input type="checkbox"/> Policy/Benefit Change To An Existing Policy <i>List Type Of Change Requested: _____</i>
<input type="checkbox"/> Applying for Preferred Rates	<input type="checkbox"/> Reinstatement of Coverage
<input type="checkbox"/> Removal of Condition Specific Deductible or Special Exception Rider	

## PERSON(S) TO BE INSURED

	Last	Name First	M.I.	Sex	Age	Birthdate MM/DD/YY	State of Birth	Height	Weight	Social Security Number
1. PRIMARY										
2. SPOUSE [/DOMESTIC PARTNER] [/CIVIL UNION]										
3. DEPENDENT(S)	Last	Name First	M.I.	Sex	Age	Birthdate MM/DD/YY	Full-Time Student?	Height	Weight	Social Security Number

4a. Resident Address: \_\_\_\_\_  
(Street) (City) (State) (ZIP)

4b. E-mail Address: \_\_\_\_\_

5. Does any proposed insured live outside the above household? .....  Yes  No

If "Yes," explain. \_\_\_\_\_

6. Phone Number: (\_\_\_\_\_) \_\_\_\_\_ [Please list the phone number that would be the best to reach you during the day to inquire about medical history. (\_\_\_\_\_) \_\_\_\_\_]

- 7a. **Primary Insured Occupation:** \_\_\_\_\_  
 Company Name: \_\_\_\_\_ Work Number: (\_\_\_\_\_) \_\_\_\_\_  
 Duties: \_\_\_\_\_  
 Is the Primary Insured [self-employed] [or] [a sole proprietor]? .....  Yes  No  
 Is the Primary Insured covered by Workers' Compensation? .....  Yes  No
- 7b. **Spouse[/Domestic Partner] [/Civil Union] Occupation:** \_\_\_\_\_  
 Company Name: \_\_\_\_\_ Work Number: (\_\_\_\_\_) \_\_\_\_\_  
 Duties: \_\_\_\_\_  
 Is the Spouse[/Domestic Partner] [/Civil Union] [self-employed] [or] [a sole proprietor]? .....  Yes  No  
 Is the Spouse[/Domestic Partner] [/Civil Union] covered by Workers' Compensation? .....  Yes  No

**COMPLETE IF REQUESTING LIFE INSURANCE COVERAGE**

- [8.] Beneficiary for Primary Insured: \_\_\_\_\_  
(Full Name) (Relationship)  
 Contingent Beneficiary: \_\_\_\_\_  
(Full Name) (Relationship)  
*The Primary Insured is the beneficiary of any Spouse [/Domestic Partner] [/Civil Union] or Child(ren) Life Insurance.]]*

**OTHER COVERAGE IN FORCE OR APPLIED FOR**

- [9.] [Are any of the proposed insureds covered by, or has application been made for any type of medical insurance? .....  Yes  No]  
 [If "Yes," complete the section below.]

Proposed Insured's Name	Insurance Company Name	Group or Individual	Type of Coverage	Effective Date (MM/DD/YY)	Termination Date (MM/DD/YY)	Is this coverage being replaced by proposed coverage?

- [10.] [Were all proposed insureds covered under the prior plan listed above? .....  Yes  No]  
 [If "No," list those not covered. \_\_\_\_\_]

- [11.] [Have any of the proposed insureds ever been declined, postponed, charged an extra premium or had a portion of coverage excluded for life, disability, or medical insurance or had such coverage rescinded?  Yes  No]  
 [If "Yes," give details. \_\_\_\_\_]  
 \_\_\_\_\_]

**HAZARDOUS ACTIVITIES AND DRIVING**

- [12.] [Have any of the proposed insureds [ever] [in the past [10 years]] participated in organized racing including but not limited to, automobile, motorcycle or powerboat racing or any of the following activities: skydiving; ultralight flying; scuba diving; hang gliding; rock or mountain climbing? .....  Yes  No]  
 [If "Yes," indicate: **Who and Which Activity**      **When/How Often**      **Do you plan continued participation?**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_]

- [13.] [Have any of the proposed insureds been cited for driving while intoxicated in the past [5] years or had [2] or more moving violations in the past [2] years?  Yes  No]  
 If "Yes," indicate type of violation: \_\_\_\_\_ Date(s): \_\_\_\_\_]

**BILLING**

Monthly Check-O-Matic]  Quarterly]  Semi-Annual]  Annual]  List Bill (monthly only)]

[Credit Card:]  First Payment Only\*]  Monthly]  Quarterly]  Semi-Annual]  Annual]

[\*With this option, you must select a secondary billing mode other than list bill for subsequent payments. Please make selection above and provide all necessary information.]

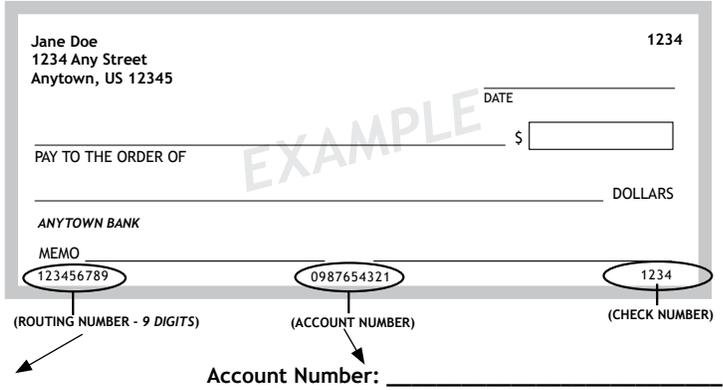
If billing address is different than resident address, please complete:

Payor Name \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**AUTHORIZATION FOR CHECK-O-MATIC BILLING ONLY – Choose the following option that applies:**

**To begin Check-O-Matic withdrawals:**  
 Select a desired withdrawal day (1–28): \_\_\_\_\_  
 Bank Name: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_

**To add this policy to an existing Check-O-Matic:**  
 Existing COM Number: \_\_\_\_\_  
 Associated Policy Number: \_\_\_\_\_



Routing Number: \_\_\_\_\_

Account Number: \_\_\_\_\_

**Check-O-Matic** (Complete authorization below)  
 I (we) hereby authorize John Alden Life Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, indicated on the other side, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Signature of Payor \_\_\_\_\_ Date Signed \_\_\_\_\_

**[AUTHORIZATION FOR CREDIT CARD PAYMENTS**

When selecting MasterCard/VISA Card: I authorize Assurant Health to charge my account for the Individual Medical policy listed above. I understand there will be no refund of premium after the 10-day free look period in the contract.

VISA Card Number: \_\_\_\_\_  
 MasterCard Number: \_\_\_\_\_  
 Exp. Date: \_\_\_\_ / \_\_\_\_ [Security Code Number (3 digits on back of credit card): \_\_\_\_ \_ ]  
 Name as it appears on card: \_\_\_\_\_  
 Signature of Payor: \_\_\_\_\_ Date: \_\_\_\_\_ ]

**HEALTH ADVOCATES ALLIANCE MEMBERSHIP APPLICATION**

Health Advocates Alliance is a membership organization that promotes good health among its members and their communities. Membership in the Alliance is required in order to be eligible for health insurance coverage. Membership privileges include the opportunity to participate in all programs offered or sponsored by the Association. For additional information and benefits provided by the Association please see the Health Advocates Alliance Brochure (Form JI-1033).

I hereby request enrollment in the Health Advocates Alliance. I understand that nominal dues are required for membership in the Association; if participating in a sponsored insurance program, then my annual dues may be collected in installments along with my insurance premiums. I also understand that membership dues are non-refundable, and my failure to remit membership dues will result in loss of eligibility to participate in any of the Association sponsored programs or benefits.

Member Signature \_\_\_\_\_ Date \_\_\_\_\_ ]

## HEALTH STATEMENT

**IMPORTANT! PLEASE GIVE COMPLETE DETAILS OF EACH "YES" ANSWER ON THE "ADDITIONAL MEDICAL DETAILS" PAGE.  
WITHIN THE LAST [10] YEARS HAS ANY PROPOSED INSURED:**

**[14.][HAD ANY DIAGNOSIS OF, RECEIVED TREATMENT FOR, OR CONSULTED WITH A PHYSICIAN CONCERNING:**

- [a)] [The lungs or respiratory system including but not limited to: hayfever or other allergies; sinus infections; asthma; bronchitis; tuberculosis; pneumonia or emphysema? .....  Yes  No]
- [b)] [The heart or circulatory system including but not limited to: high blood pressure; heart attack; heart murmur; chest pain; irregular heartbeat; varicose veins; phlebitis or elevated cholesterol?  Yes  No]  
[If "Yes," please provide last known blood pressure and cholesterol reading on the "Additional Medical Details" page.]
- [c)] [The digestive system including but not limited to: ulcer; gastritis; heartburn; intestinal disorder; colitis; gallbladder; hemorrhoids; hernia; disorder of the pancreas; spleen; or liver including but not limited to; hepatitis; jaundice or cirrhosis? .....  Yes  No]
- [d)] [The nervous system including but not limited to: epilepsy; seizures; unconsciousness; convulsions; vertigo; headaches; paralysis; multiple sclerosis; cerebral palsy; Parkinson's disease; stroke or mini-stroke; TIA or brain attack? .....  Yes  No]
- [e)] [Mental disease or nervous disorder including but not limited to: any emotional disorder; anxiety; depression; attention deficit disorder; eating disorder; or psychiatric treatment or counseling? ...  Yes  No]
- [f)] [Congenital disorder, birth defects or developmental disorders including but not limited to Down Syndrome; mental retardation; autism; cleft palate; club foot; or congenital heart defects?  Yes  No]
- [g)] [The genitourinary system including but not limited to: any kidney disorder; kidney stones; cystitis; prostatitis; bladder infections; or sexually transmitted disease? .....  Yes  No]
- [h)] [Diabetes, high or low blood sugar or any disorder of the thyroid gland or other glandular disorder?  Yes  No]
- [i)] [The muscular, skeletal or connective tissue disorder including but not limited to: arthritis; lupus (SLE); temporomandibular joint disease (TMJ); any back or spine disorder or treatment of any muscular or neuromuscular disorder or any manipulation therapy? .....  Yes  No]
- [j)] [Blood or lymph disorders including but not limited to anemia or lymphadenopathy? .....  Yes  No]
- [k)] [Cancer? .....  Yes  No]  
[If "Yes," provide location, type of cancer and treatment received on the "Additional Medical Details" page.]
- [l)] [Tumor, cyst or growth of any kind; any breast or skin disorders? .....  Yes  No]  
[If "Yes," provide location, state if treated or removed and date on the "Additional Medical Details" page.]
- [m)] [Any disorder of the eyes; ears (including ear infections or ear tubes); nose or throat. Tonsils or adenoids; any speech or hearing impairment? .....  Yes  No]
- [n-1)] [Any disorder of the reproductive organs, including but not limited to: disorders of the penis; testes; vagina; ovaries and cervix; uterus; diagnosed or treated for infertility or irregular menstruation?  Yes  No]
- [n-2)] [To the best of your knowledge, are you, your spouse [/domestic partner] [/civil union] or any dependent now pregnant? .....  Yes  No]
- [n-3)] [Is any person not named on this enrollment form now pregnant by any person to be insured? ...  Yes  No]

**IF EITHER [N-2] OR [N-3] IS ANSWERED "YES," MEDICAL COVERAGE CANNOT BE ISSUED.**

QUESTIONS N-4 – N-6 FOR FEMALE APPLICANTS:

- [n-4)] [Complications of pregnancy, including but not limited to caesarean section delivery or miscarriage? .....  Yes  No]
- [n-5)] [Date of Last Pap Smear: \_\_\_\_\_ Results: \_\_\_\_\_]
- [n-6)] [Have you been instructed to have a repeat Pap Smear or any follow-up treatment or tests as a result of your last Pap Smear? .....  Yes  No]

- [15.] [Been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) by a member of the medical profession? .....  Yes  No]
- [16.] [Been diagnosed as having or been treated for any immune deficiency disorder by a member of the medical profession? .....  Yes  No]
- [17.] [Experienced any of the following: Signs and symptoms of an immune deficiency disorder may include lymphadenopathy (swollen lymph nodes); loss of appetite; weight loss; chronic fatigue; fever; oral thrush; skin rashes; unexplained infections; dementia; depression; or other psychoneurotic disorders with no known cause? .....  Yes  No]
- [18.] [Had surgery or has diagnostic testing, treatment or surgery been recommended or scheduled that has not been completed? .....  Yes  No]

**HEALTH STATEMENT CONTINUED**

- [19.] [Does any person have any fixation/prosthetic devices present including but not limited to: plates; screws; pins; implants (including breast implants); shunts; pacemakers or valve replacements? .....  Yes  No]
- [20.] [Had an electrocardiogram, chest x-ray, or blood test or any other diagnostic testing of any kind or been hospital confined in the past [10] years? .....  Yes  No]  
[If "Yes," give name of physician or hospital and results on the "Additional Medical Details" page.]
- [21.] [Been a member of Alcoholics Anonymous or had any treatment, including but not limited to, counseling for alcoholism or alcohol abuse or been advised by a physician to discontinue or decrease alcohol consumption? .....  Yes  No]
- [22.] [Used sedatives; tranquilizers; cocaine or other hallucinogenic or narcotic drugs; or received treatment for drug abuse or chemical dependency? .....  Yes  No]

**ADDITIONAL QUESTIONS**

- [23.] [To the best of your knowledge, does any person to be insured have any mental or physical impairment, disease or deformity not indicated above? .....  Yes  No]
- [24a.] [Have you or your spouse [/domestic partner] [/civil union] (if to be insured) smoked cigarettes or used tobacco in any form or nicotine substitute within the past year? PRIMARY INSURED .....  Yes  No]  
[SPOUSE [/DOMESTIC PARTNER] [/CIVIL UNION] (if to be insured) .....  Yes  No]
- [24b.] [Have you or your spouse [/domestic partner] [/civil union] EVER smoked cigarettes or used tobacco products? .....  Yes  No]  
[If "Yes," indicate who, amount per day and year quit on the "Additional Medical Details" page.]
- [25.] [Is any proposed insured currently taking, or taken within the past [12] months, any prescription medication, or receiving medical treatment of any kind [or is currently taking, or taken, any non prescription medication on a daily basis? .....  Yes  No]  
[If "Yes," provide details of treatment including name and dosage of all medications on the "Additional Medical Details" page.]

**REQUESTING THE REMOVAL OF A SPECIAL CLASS PREMIUM, SPECIAL EXCEPTION RIDER OR CONDITION SPECIFIC DEDUCTIBLE**

- [26.] [Has there been any medical treatment or medication use for, or have you consulted with a physician concerning the condition(s) which has had a Condition Specific Deductible, been ridered or rated since the covered person's effective date? .....  Yes  No]  
[If "Yes," provide details on the "Additional Medical Details" page.]

**OTHER PHYSICIANS**

- [27.] [Regular physician or medical practitioner for each proposed insured. If none, provide last physician seen, date, reason and results.  
**Primary Proposed Insured's Physician** \_\_\_\_\_  
Address \_\_\_\_\_  
Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_  
**Spouse's [/Domestic Partner's] [/Civil Union's] Physician** \_\_\_\_\_  
Address \_\_\_\_\_  
Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_  
**Child's Name** \_\_\_\_\_ **Physician** \_\_\_\_\_  
Address \_\_\_\_\_  
Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_  
**Child's Name** \_\_\_\_\_ **Physician** \_\_\_\_\_  
Address \_\_\_\_\_  
Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_  
**Child's Name** \_\_\_\_\_ **Physician** \_\_\_\_\_  
Address \_\_\_\_\_  
Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_ ]



**EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT**

You understand and agree that you are applying for individual health insurance for you (and your family). You further understand that this application for health insurance will be fully medically underwritten and that coverage is not guaranteed. You are personally paying the entire premium for this health insurance coverage. Your employer is not contributing in any way to the payment of premium, either directly or indirectly.

Do you agree with this statement? .....  Yes  No]

**AUTHORIZATION**

[I represent to the best of my knowledge and belief, that all statements and answers on this enrollment form are complete and true. The enrollment form and any amendments shall be the basis for the contract. I also agree that:

Except as otherwise provided in the Conditional Receipt, the insurance, if approved by John Alden Life Insurance Company, will be in force only when issued by John Alden Life Insurance Company. The first full premium must be paid. Coverage will become effective on the later of: A) The date we receive the enrollment form; B) the requested Effective Date. A change in the health of the proposed insured(s) after the completion of the enrollment form and before the delivery of the contract may affect my eligibility for insurance with the company. The contract may only be effective prior to the contract delivery subject to the terms of the Conditional Receipt.]

[I agree that a photographic copy of this authorization shall be valid for two years from the date signed.]

[I acknowledge receiving the notification regarding [MIB, Inc.,] the Abbreviated Notice of Insurance Information Practices and the Outline of Coverage for Health Insurance, if required.]

[We, the undersigned Proposed Insured(s) and agent, acknowledge that the Proposed Insured(s) has read the completed enrollment form. We understand and acknowledge that any fraudulent statement or material misrepresentation or omission on the enrollment form and/or any amendments may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provisions of the contract.]

[I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, [MIB Inc.], consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested to John Alden Life Insurance Company, its legal representative or any medical records retrieval service John Alden Life Insurance Company may engage, including, but not limited to, [EMSI] and its agents.]

[This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs. This information may also be disclosed to [MIB, Inc.] and any medical records company engaged by John Alden Life Insurance Company, including but not limited to [EMSI] and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by John Alden Life Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as an original.]

[I understand that this authorization is required in order to enable John Alden Life Insurance Company to make eligibility or enrollment determinations relating to me and/or my minor children or for John Alden Life Insurance Company's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, John Alden Life Insurance Company may refuse to consider my application for enrollment.]

[I understand that I may revoke this authorization at any time by notifying John Alden Life Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, John Alden Life Insurance Company, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if John Alden Life Insurance Company has taken action in reliance on the authorization.]

[Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: [30] days after denial of my application, or declination of enrollment, or, if insured, [30] days after when I am no longer an insured of John Alden Life Insurance Company. But in no event will this authorization be in effect for longer than [24] months from the date signed.]

\_\_\_\_\_  
Signature of Primary Proposed Insured

\_\_\_\_\_  
Signature of Spouse[/Domestic Partner] [/Civil Union]  
or Other (if proposed to be insured)

\_\_\_\_\_  
Signature(s) of Other Dependent(s) 18 or Over  
(if proposed to be insured)

\_\_\_\_\_  
Guardian's Signature

Requested Effective Date: \_\_\_\_\_

Premium Amount Sent: \$ \_\_\_\_\_

One-time Processing Fee Sent\*: \_\_\_\_\_

\*Not applicable in all states

Conditional Receipt Taken:  Yes  No

\_\_\_\_\_  
Date Signed      \_\_\_\_\_<sup>A.M. / P.M.</sup> Time Signed      \_\_\_\_\_ City      \_\_\_\_\_ State

Attention: (Agent)  
I have reviewed this enrollment form to ensure that all required items have been completed.  
To the best of knowledge, there  IS  IS NOT a replacement of medical insurance involved in this transaction.  
Are you aware of any mental or physical impairment, disease, or deformity of any proposed insured which is not disclosed on the enrollment form?  Yes  No  
If "Yes," please explain. \_\_\_\_\_  
\_\_\_\_\_  
Licensed Resident Agent's Signature  
\_\_\_\_\_  
Print Agent's Name  
\_\_\_\_\_  
Initial here if you witnessed the signing of this form by the proposed insured.

## ADDITIONAL NOTICES

### [NOTIFICATION REGARDING [MIB, Inc.] (“MIB”)] [formerly known as the Medical Information Bureau]

Information regarding your insurability will be treated as confidential. John Alden Life Insurance 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 or health insurance coverage, or a claim for benefits is submitted to such a company, [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 the 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 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734].

John Alden Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life, or health insurance or to whom a claim for benefits may be submitted. Information for consumers about [MIB] may be obtained on its website at [www.mib.com].]

### ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact John Alden Life Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.

### FRAUD NOTICE

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.

### PRIVACY

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on enrollment forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.]

## CONDITIONAL RECEIPT

This Conditional Receipt is received from \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_ (month) \_\_\_\_\_ (year).

If full premium is paid and John Alden Life Insurance Company accepts this application as applied for within (30) days of the date the application is signed, the effective date will be as specified above, but I agree that I have no insurance coverage

under this application until John Alden Life Insurance Company notifies me in writing that my application is approved. No agent or broker of the Company is authorized to alter or waive the conditions of this conditional receipt.

For coverage to become effective, each individual to be covered must be a risk acceptable to John Alden Life Insurance Company as applied for and at a standard or preferred rate with no Special Exception Riders on the later of: the Requested Effective Date or the Date on which John Alden Life Insurance Company receives the application at its home office.

I understand that John Alden Life Insurance Company has the right to deny my application and if it does so I will be notified in writing and the premium I submitted will be returned.

If I do not select an effective date, John Alden Life Insurance Company will assign an effective date that is later than the date the application is approved.

I must advise John Alden Life Insurance Company of any change in information included in the application for me or any person to be insured that occurs after the date I sign the application until the later of the effective date of coverage or the date John Alden Life Insurance Company receives the application at its home office. Failure to update John Alden Life Insurance Company regarding these changes may result in coverage being voided.]

# Tele-App Part 1 Enrollment Form for Medical Insurance for Individuals and Families

PLEASE PRINT IN BLACK INK

## AGENT/AGENCY INFORMATION

Agent Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Agent Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
 Key Agency Contact: \_\_\_\_\_ Agency Name: \_\_\_\_\_  
 Fax Number: \_\_\_\_\_ Agency Number: \_\_\_\_\_  
 Sales Representative Number: \_\_\_\_\_

## TYPE OF ACTIVITY *(Please check appropriate box.)*

**NEW** *If not a new enrollee, check appropriate box and list affected policy number.*

**CHANGE/ADDITION TO AN EXISTING POLICY.** POLICY # \_\_\_\_\_

Internal Replacement

Conversion (over age dependent/divorce)

## PERSON(S) TO BE INSURED

	Last	Name First	MI	Sex	Age	Birthdate (MM/DD/YY)	State of Birth	Social Security Number
1. PRIMARY								
2. SPOUSE[/ DOMESTIC PARTNER] [/CIVIL UNION]								
3. DEPENDENT(S) <i>(list relationship)</i>	Last	Name First	MI	Sex	Age	Birthdate (MM/DD/YY)	Full-time Student?	Social Security Number

4. Resident Address: \_\_\_\_\_  
 (NO P.O. BOXES) (Street) (City) (State) (ZIP)

[5.] [Phone Number: (\_\_\_\_\_) \_\_\_\_\_] 6. E-mail Address: \_\_\_\_\_

7a. Are any of the proposed insureds covered by any type of medical insurance? .....  Yes (Complete section below)  
 .....  No

Proposed Insured's Name	Insurance Company Name	Group or Individual	Type of Coverage	Effective Date (MM/DD/YY)	Termination Date (MM/DD/YY)	Is this coverage being replaced by proposed coverage?

**[REMEMBER TO FAX PAGES 1, 2, 3 & 4 AND THE SOFTWARE PROPOSAL TO [414-299-6020]]**

7b. Primary Insured Occupation: \_\_\_\_\_  
 Company Name: \_\_\_\_\_ Work Number: (\_\_\_\_) \_\_\_\_\_  
 Duties: \_\_\_\_\_  
 Is the Primary insured [self-employed] [or] [a sole proprietor]? . . . . .  Yes  No  
 Is the Primary Insured covered by Workers' Compensation? . . . . .  Yes  No

7c. Spouse [/Domestic Partner] [/Civil Union] Occupation: \_\_\_\_\_  
 Company Name: \_\_\_\_\_ Work Number: (\_\_\_\_) \_\_\_\_\_  
 Duties: \_\_\_\_\_  
 Is the Spouse[/ Domestic Partner] [/Civil Union] [self-employed] [or] [a sole proprietor]? . . . . .  Yes  No  
 Is the Spouse[/ Domestic Partner] [/Civil Union] covered by Workers' Compensation? . . . . .  Yes  No

**BILLING**

Monthly Check-O-Matic  Quarterly  Semi-Annual  Annual  List Bill (monthly only)

[Credit Card:]  First Payment Only\*  Monthly  Quarterly  Semi-Annual  Annual

[\*With this option, you must select a secondary billing mode other than list bill for subsequent payments. Please make selection above and provide all necessary information.]

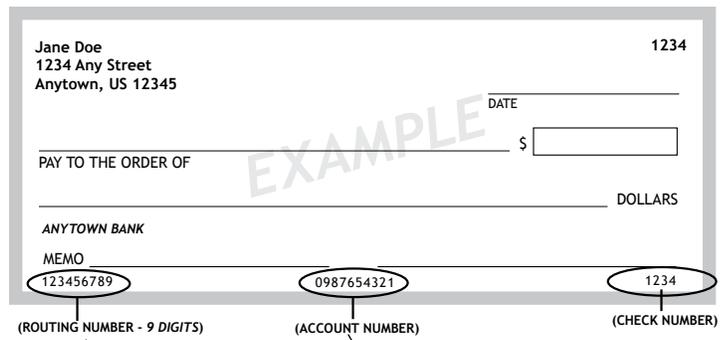
If billing address is different than resident address, please complete:

Payor Name	Address	City	State	ZIP
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**AUTHORIZATION FOR CHECK-O-MATIC BILLING ONLY – Choose the following option that applies:**

**To begin Check-O-Matic withdrawals:**  
 Select a desired withdrawal day (1–28): \_\_\_\_\_  
 Bank Name: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_

**To add this policy to an existing Check-O-Matic:**  
 Existing COM Number: \_\_\_\_\_  
 Associated Policy Number: \_\_\_\_\_



Routing Number: \_\_\_\_\_

Account Number: \_\_\_\_\_

**Check-O-Matic** (Complete authorization below)  
 I (we) hereby authorize John Alden Life Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, indicated on the other side, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Signature of Payor \_\_\_\_\_ Date Signed \_\_\_\_\_

**[AUTHORIZATION FOR CREDIT CARD PAYMENTS**

When selecting MasterCard/VISA Card: I authorize Assurant Health to charge my account for the Individual Medical policy listed above. I understand there will be no refund of premium after the 10-day free look period in the contract.

VISA Card Number: \_\_\_\_\_

MasterCard Number: \_\_\_\_\_

Exp. Date: \_\_\_\_ / \_\_\_\_ [Security Code Number (3 digits on back of credit card): \_\_\_\_ \_ ]

Name as it appears on card: \_\_\_\_\_

Signature of Payor: \_\_\_\_\_ Date: \_\_\_\_\_ ]

**[REMEMBER TO FAX PAGES 1, 2, 3 & 4 AND THE SOFTWARE PROPOSAL TO [414-299-6020]]**

**COMPLETE IF REQUESTING LIFE INSURANCE COVERAGE**

Beneficiary for Primary Insured: \_\_\_\_\_  
(Full Name) (Relationship)

Contingent Beneficiary: \_\_\_\_\_  
(Full Name) (Relationship)

*The Primary Insured is the beneficiary of any Spouse [ / Domestic Partner ] [ / Civil Union ] or Child(ren) Life Insurance.*

**HEALTH ADVOCATES ALLIANCE MEMBERSHIP APPLICATION**

Health Advocates Alliance is a membership organization that promotes good health among its members and their communities. Membership in the Alliance is required in order to be eligible for health insurance coverage. Membership privileges include the opportunity to participate in all programs offered or sponsored by the Association. For additional information and benefits provided by the Association please see the Health Advocates Alliance Brochure (Form JI-1033).

I hereby request enrollment in the Health Advocates Alliance. I understand that nominal dues are required for membership in the Association; if participating in a sponsored insurance program, then my annual dues may be collected in installments along with my insurance premiums. I also understand that membership dues are non-refundable, and my failure to remit membership dues will result in loss of eligibility to participate in any of the Association sponsored programs or benefits.

\_\_\_\_\_  
Member Signature Date ]

**[REMEMBER TO FAX PAGES 1, 2, 3 & 4 AND THE SOFTWARE PROPOSAL TO [414-299-6020]]**

**EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT**

You understand and agree that you are applying for individual health insurance for you (and your family). You further understand that this application for health insurance will be fully medically underwritten and that coverage is not guaranteed. You are personally paying the entire premium for this health insurance coverage. Your employer is not contributing in any way to the payment of premium, either directly or indirectly.

Do you agree with this statement? . . . . .  Yes  No]

**AUTHORIZATION**

In order to determine my (our) eligibility for insurance, I authorize any licensed physician, medical practitioner, hospital, clinic, any pharmacy, pharmacy benefit manager or pharmacy-related entity, any medically-related facility, insurance company, [MIB, Inc.,] employer, or consumer-reporting agency to give John Alden Life Insurance Company (or any consumer-reporting agency authorized by John Alden Life Insurance Company) any information regarding me or my family as to employment, other insurance coverage, personal information, and medical or pharmacy care, advice or treatment, or medication use.

I represent to the best of my knowledge and belief, that all statements and answers on Part 1 are complete and true. My recorded Personal Health History, Part 1 and any amendments shall be the basis for the contract. I also agree that: (1) Within 30 days of policy delivery, I must formally accept the offer by verifying the accuracy of the enrollment form information with a signature and returning that signed acceptance to John Alden Life Insurance Company. (2) Except as otherwise provided in the Conditional Receipt, the insurance, if approved by John Alden Life Insurance Company, will be in force only when issued by John Alden Life Insurance Company and accepted by me. (3) I understand and agree that any information I provide through this application process may be shared with persons necessary to facilitate issuing coverage, including but not limited to my agent or broker. (4) If any of these conditions are not met, John Alden Life Insurance Company has the right to rescind its offer of coverage and the full extent of its liability shall be limited to the sum received, subject to the Time Limit on Certain Defenses.

[I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, [MIB, Inc.,] consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested to John Alden Life Insurance Company, its legal representative or any medical records retrieval service John Alden Life Insurance Company may engage, including, but not limited to, [EMSI] and its agents.]

[This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs. This information may also be disclosed to [MIB, Inc.] and any medical records company engaged by John Alden Life Insurance Company, including but not limited to [EMSI] and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by John Alden Life Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as an original.]

[I understand that this authorization is required in order to enable John Alden Life Insurance Company to make eligibility or enrollment determinations relating to me and/or my minor children or for John Alden Life Insurance Company's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, John Alden Life Insurance Company may refuse to consider my application for enrollment.]

[I understand that I may revoke this authorization at any time by notifying John Alden Life Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, John Alden Life Insurance Company, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if John Alden Life Insurance Company has taken action in reliance on the authorization.]

[Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: [30] days after denial of my application, or declination of enrollment, or, if insured, [30] days after when I am no longer an insured of John Alden Life Insurance Company. But in no event will this authorization be in effect for longer than [24] months from the date signed.]

\_\_\_\_\_  
Signature of Primary Proposed Insured

\_\_\_\_\_  
Signature of Spouse or Other Insured (if proposed to be insured)

(Circle one)  
A.M. / P.M.

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Time Signed

\_\_\_\_\_  
City & State

\_\_\_\_\_  
Requested Policy Effective Date

Conditional Receipt Given?  Yes  No

**[REMEMBER TO FAX PAGES 1, 2, 3 & 4 AND THE SOFTWARE PROPOSAL TO [414-299-6020]]**

## ADDITIONAL NOTICES

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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 the 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 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734].

John Alden Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about [MIB] may be obtained on its website at [www.mib.com].]

### ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

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## CONDITIONAL RECEIPT

This Conditional Receipt is received from \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_ (month) \_\_\_\_\_(year).

If full premium is paid and John Alden Life Insurance Company accepts this application as applied for within (30) days of the date the application is signed, the effective date will be as specified above, but I agree that I have no insurance coverage under this application until John Alden Life Insurance Company notifies me in writing that my application is approved. No agent or broker of the Company is authorized to alter or waive the conditions of this conditional receipt.

For coverage to become effective, each individual to be covered must be a risk acceptable to John Alden Life Insurance Company as applied for and at a standard or preferred rate with no Special Exception Riders on the later of: the Requested Effective Date or the Date on which the Personal Health History call is completed.

I understand that John Alden Life Insurance Company has the right to deny my application and if it does so I will be notified in writing and the premium I submitted will be returned. If I do not select an effective date, John Alden Life Insurance Company will assign an effective date that is later than the date the application is approved.

I must advise John Alden Life Insurance Company of any change in information included in the application for me or any person to be insured that occurs after the date I sign the application until the later of the effective date of coverage or the date on which the Personal Health History call is completed. Failure to update John Alden Life Insurance Company regarding these changes may result in coverage being voided.

**LEAVE THIS PAGE WITH THE CUSTOMER - DO NOT FAX**

Policy #: \_\_\_\_\_

## Acceptance of Offer and Attestation

I represent to the best of my knowledge and belief, that all statements and answers on this enrollment form are complete and true. My recorded Personal Health History, the enrollment form and any amendments shall be the basis for the offer of coverage. I also agree that:

Except as otherwise provided in the Conditional Receipt, the insurance, if approved by John Alden Life Insurance Company, will be in force only when issued by John Alden Life Insurance Company. I shall sign the enrollment form and obtain the signatures of my Spouse [Domestic Partner] [Civil Union] and any covered dependents over the age of 18, and return it to John Alden Life Insurance Company within 30 days of the contract issue. If acceptance is not received within 30 days, John Alden Life Insurance Company reserves the right to revoke any and all such offers. The first full premium must be paid. The contract may only be effective prior to the contract delivery and acceptance, if all the terms of the Conditional Receipt have been fulfilled.

I agree that a photocopy of this authorization shall be valid for two years from the date signed. I acknowledge receiving the Fair Credit Reporting Act Pre-Notification, the notification regarding [MIB, Inc.,] the Privacy statement concerning my personal health information, the Abbreviated Notice of Insurance Information Practices, and the Outline of Coverage for Health Insurance, if required.

We, the undersigned proposed insured(s) and agent acknowledge that the proposed insured(s) has read the completed enrollment form. We understand and acknowledge that any fraudulent statement or material misrepresentation on the enrollment form and/or any amendments may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provisions of the contract.

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
State

\_\_\_\_\_  
Signature of Spouse or Other Insured

\_\_\_\_\_  
Signature(s) of Other Dependents 18 or Over

\_\_\_\_\_  
Guardian's Signature

*[If Life Insurance is issued, complete this section.]*

Beneficiary for Primary Insured:

\_\_\_\_\_  
Full Name and Relationship

Contingent Beneficiary:

\_\_\_\_\_  
Full Name and Relationship

*(The Primary Insured is the Beneficiary of any spouse [domestic partner] [civil union] or child(ren) life insurance.)*

# Enrollment Form for Medical Insurance for Individuals and Families

## AGENT/AGENCY INFORMATION

Agent Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Agent Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
 Key Agency Contact: \_\_\_\_\_ Agency Name: \_\_\_\_\_  
 Fax Number: \_\_\_\_\_ Agency Number: \_\_\_\_\_

## TYPE OF ACTIVITY *(Please check appropriate box.)*

**NEW** *If not a new enrollee, check appropriate box and list affected policy number.*

**CHANGE/ADDITION TO AN EXISTING POLICY.** POLICY # \_\_\_\_\_

Internal Replacement

Conversion (over age dependent/divorce)

## PERSON(S) TO BE INSURED

	Last	Name First	M.I.	Sex	Age	Birthdate MM/DD/YY	State of Birth	Height	Weight	Social Security Number
1. PRIMARY										
2. SPOUSE [ /DOMESTIC PARTNER ] [ /CIVIL UNION ]										
3. DEPENDENT(S)	Last	Name First	M.I.	Sex	Age	Birthdate MM/DD/YY	Full-Time Student?	Height	Weight	Social Security Number

4a. Resident Address: \_\_\_\_\_  
(Street) (City) (State) (ZIP)

4b. E-mail Address: \_\_\_\_\_

[5.] [Does any proposed insured live outside the above household? .....  Yes  No  
 If "Yes," explain. \_\_\_\_\_]

[6.] [Phone Number: (\_\_\_\_\_) \_\_\_\_\_ [Please list the phone number that would be the best to reach you during the day to inquire about medical history. (\_\_\_\_\_) \_\_\_\_\_]

[7a.] **Primary Insured Occupation:** \_\_\_\_\_  
 Company Name: \_\_\_\_\_ Work Number: (\_\_\_\_\_) \_\_\_\_\_  
 Duties: \_\_\_\_\_  
 Is the Primary Insured [self-employed] [or] [a sole proprietor]? .....  Yes  No  
 Is the Primary Insured covered by Workers' Compensation? .....  Yes  No

[7b.] **Spouse[/Domestic Partner] [/Civil Union] Occupation:** \_\_\_\_\_  
 Company Name: \_\_\_\_\_ Work Number: (\_\_\_\_\_) \_\_\_\_\_  
 Duties: \_\_\_\_\_  
 Is the Spouse[/Domestic Partner] [/Civil Union] [self-employed] [or] [a sole proprietor]? .....  Yes  No  
 Is the Spouse[/Domestic Partner] [/Civil Union] covered by Workers' Compensation? .....  Yes  No

**OTHER COVERAGE IN FORCE OR APPLIED FOR**

[8.] [Are any of the proposed insureds covered by, or has application been made for any type of medical insurance? .....  Yes  No]  
 [If "Yes," complete the section below.]

Proposed Insured's Name	Insurance Company Name	Group or Individual	Type of Coverage	Effective Date (MM/DD/YY)	Termination Date (MM/DD/YY)	Is this coverage being replaced by proposed coverage?

[9.] [Were all proposed insureds covered under the prior plan listed above? .....  Yes  No]

[10.] [Have any of the proposed insureds within the last [10] years been declined, postponed, rescinded, reformed, charged an extra premium or had a portion of coverage excluded for life, disability, or medical insurance? .....  Yes  No]  
 If "Yes," give details. \_\_\_\_\_  
 \_\_\_\_\_ ]

**HAZARDOUS ACTIVITIES AND DRIVING**

[11.] [In the last [10] years, have any of the proposed insureds participated in any motorized vehicle racing (includes drivers, pit crew, owners or mechanics) or any of the following activities: skydiving, ultralight flying, scuba diving, hang gliding, rock or mountain climbing or rodeo participation? .....  Yes  No]

[12.] [In the last [10] years, have any of the proposed insureds been cited for operating a motor vehicle under the influence of alcohol or drugs? .....  Yes  No]

**BILLING**

Monthly Check-O-Matic]  Quarterly]  Semi-Annual]  Annual]  List Bill (monthly only)]

[Credit Card:]  First Payment Only\*]  Monthly]  Quarterly]  Semi-Annual]  Annual]

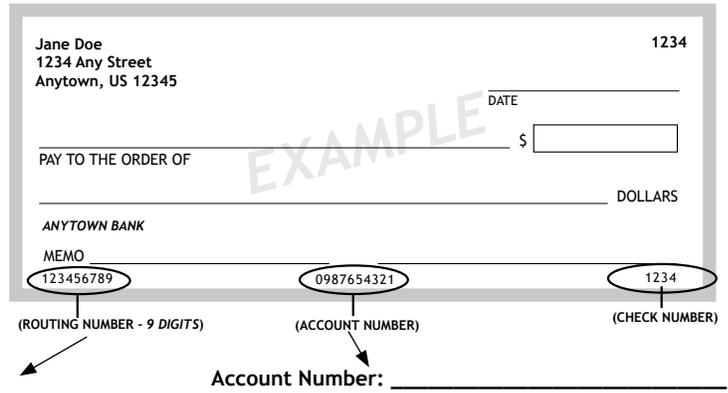
[\*With this option, you must select a secondary billing mode other than list bill for subsequent payments. Please make selection above and provide all necessary information.]

If billing address is different than resident address, please complete:

Payor Name	Address	City	State	ZIP
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**AUTHORIZATION FOR CHECK-O-MATIC BILLING ONLY - Choose the following option that applies:**

- To begin Check-O-Matic withdrawals:**  
 Select a desired withdrawal day (1-28): \_\_\_\_\_  
 Bank Name: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_
  - To add this policy to an existing Check-O-Matic:**  
 Existing COM Number: \_\_\_\_\_  
 Associated Policy Number: \_\_\_\_\_
- Routing Number: \_\_\_\_\_



- Check-O-Matic** (Complete authorization below)  
 I (we) hereby authorize John Alden Life Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, indicated on the other side, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Signature of Payor	Date Signed
--------------------	-------------

**[AUTHORIZATION FOR CREDIT CARD PAYMENTS**

When selecting MasterCard/VISA Card: I authorize Assurant Health to charge my account for the Individual Medical policy listed above. I understand there will be no refund of premium after the 10-day free look period in the contract.

- VISA Card Number: \_\_\_\_\_
- MasterCard Number: \_\_\_\_\_
- Exp. Date: \_\_\_\_ / \_\_\_\_ [Security Code Number (3 digits on back of credit card): \_\_\_\_ \_ ]

Name as it appears on card: \_\_\_\_\_

Signature of Payor: \_\_\_\_\_ Date: \_\_\_\_\_]

## HEALTH STATEMENT

### For Questions [13]-[25,] WITHIN THE LAST [10] YEARS, HAS ANY PROPOSED INSURED:

*[Note: any follow-up visits in the last [10] years as a result of a diagnosis over [10] years ago must be disclosed.]*

- [13.] [Had surgery [in a hospital or outpatient facility]? .....  Yes  No]
- [14.] [Had medical treatment in a hospital or outpatient facility? .....  Yes  No]
- [15.] [Had any urgent care or emergency room visits? .....  Yes  No]
- [16.] [Received treatment, testing, consulted with or received a diagnosis from a physician or healthcare provider? [Do NOT include annual physical exams]. .....  Yes  No]
- [17.] [Had any testing [with abnormal findings] or tests for which you have not received results? .....  Yes  No]
- [18.] [Been recommended or scheduled for diagnostic testing, consultations, treatment, follow-up or surgery that has not been completed? .....  Yes  No]
- [19.] [Received or recommended to have any treatment for alcoholism, alcohol or drug abuse or addiction, including but not limited to, counseling or attendance at support groups? .....  Yes  No]
- [20.] [Used illegal drugs or prescription medication other than as prescribed or been advised by a physician or health care provider to discontinue or decrease alcohol consumption or drug use? .....  Yes  No]

### Additional Questions

- [21.] [Has any proposed insured taken or been advised to take any prescription medication in the last [[10] years] [[12] months]? .....  Yes  No]
- [22.] [Has any proposed adult [ever] used tobacco products in any form or nicotine substitutes within the last [10] years? .....  Yes  No]
- [23.] [Has any proposed insured had a diagnosis, treatment or follow-up for cancer in the last [10] years? .....  Yes  No]
- [24.] [Is any proposed insured currently pregnant, an expectant parent or in the process of adoption or surrogate pregnancy? .....  Yes  No]
- [25.] [Have you fully disclosed all medical conditions for you and your family within the last [10] years? ...  Yes  No]

## ADDITIONAL NOTICES

### **[NOTIFICATION REGARDING [MIB, Inc.] [("MIB")] [formerly known as the Medical Information Bureau]**

Information regarding your insurability will be treated as confidential. John Alden Life Insurance 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 or health insurance coverage, or a claim for benefits is submitted to such a company, [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 the 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 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734].

John Alden Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about [MIB] may be obtained on its website at [www.mib.com].]

### **ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES**

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact John Alden Life Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.

### **FRAUD NOTICE**

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.

### **PRIVACY**

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on enrollment forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.

**ADDITIONAL NOTES**



<i>SERFF Tracking Number:</i>	<i>ASWX-126587080</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>John Alden Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>45437</i>
<i>Company Tracking Number:</i>	<i>IHAR01143JAF02</i>		
<i>TOI:</i>	<i>H16G Group Health - Major Medical</i>	<i>Sub-TOI:</i>	<i>H16G.001C Any Size Group - Other</i>
<i>Product Name:</i>	<i>John Alden-Base Chassis</i>		
<i>Project Name/Number:</i>	<i>John Alden-Base Chassis/IH AR01143JAF02</i>		

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	04/20/2010
<b>Comments:</b>		
<b>Attachment:</b>		
AR - READABILITY CERTIFICATION.PDF		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application	Approved-Closed	04/20/2010
<b>Bypass Reason:</b> The forms being filed are applications. Please see the forms schedule.		
<b>Comments:</b>		

**STATE OF ARKANSAS**  
**READABILITY CERTIFICATION**

**COMPANY NAME: John Alden Life Insurance Company**

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

<b>Form Number</b>	<b>Score</b>
JI-2300 (Rev. 4/2010)	51.1
JI-2400 (Rev. 4/2010)	51.5
JI-2500 (Rev. 4/2010)	52.3

Signed:   
Name: Julia Hix-Royer  
Title: VP Regulatory Compliance & AH  
Compliance Officer  
Date: April 15, 2010