

Short-Term Plan Application

Applicant Name:		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Persons Proposed for Coverage	Relationship	Date of Birth Mo. Day Yr.	Age	Soc. Sec. No.
Address No. and Street		Applicant		XXX	/ /		
City State Zip Code					/ /		
Work Phone Home Phone () ()					/ /		

SELECT ▶

Requested Effective Date: <input type="checkbox"/> Day after U.S. Postmark Date Stamp <input type="checkbox"/> Later Effective Date _____	Deductible: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1000 <input type="checkbox"/> \$2500 Coinsurance up to \$5000: <input type="checkbox"/> Option A - 80/20 <input type="checkbox"/> Option B - 50/50	Payment Method: <input type="checkbox"/> Monthly Payments <input type="checkbox"/> Credit Card <input type="checkbox"/> Automatic Monthly Bank Withdrawal
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1. Yes No Are you a U.S. citizen? If No, you must provide proof of an alien resident card, visa, or student visa. Please attach this proof with your application.
ANSWER THE FOLLOWING MEDICAL HISTORY QUESTIONS:

All questions must be answered for you and any person to be insured. If you or any person to be insured answers "YES" to any of the questions, coverage cannot be issued.

	Applicant	Spouse	Children
2. Within the last three years, have you or any person to be insured been aware of, diagnosed and/or been treated by a member of the medical profession for: heart disease or disorder, stroke, cancer, alcohol or drug dependency, mental disorder, emphysema, airway or pulmonary disease, Crohn's disease or ulcerative colitis, nervous system disorder, liver disorder, kidney disorder, crippling or disabling arthritis, spinal disc disease, knee or hip disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you or any person to be insured been hospitalized (except for childbirth) within the past 12 months, due to being confined, or disabled for more than a total of five days?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you or any person to be insured been ridered or declined for insurance due to health reasons?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Are you, your spouse, or any dependent currently pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. During the last five years, have you or any person to be insured been diagnosed or treated for immune deficiency syndrome (AIDS) or AIDS related complex (ARC) or tested positive for HIV?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

I have read this application and have verified that all of the information provided in it is complete, true and correct, and is all within my personal knowledge. I agree to immediately notify the Insurer of any changes in any of the information contained in this form which may occur prior to the approval of coverage. I understand that HPA will not pay benefits during the term of this coverage for loss due to any medical condition or illness I, or any person to be insured may now have or have had in the past 36 months. Any material misstatement or omission of information made on this form will be considered a misrepresentation and may be the basis for rescission of my coverage and that of my dependents. I also hereby acknowledge receipt of the "Protecting Your Privacy" and "Protecting Your Health Information" notices. I understand that I may request an additional copy of these notices at any time.

Signature of Applicant: X _____ Date: _____

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Make check payable and mail to:

Health Plan Administrators, Inc. PO Box 15250 Rockford, IL 61132-5250

<p>CREDIT CARD PAYMENT REQUEST: I authorize Health Plan Administrators, Inc to bill my: <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover account(s) For _____ months of premiums/fees. Account Number: _____ Expiration Date: _____ _____ Signature of Cardholder _____ Date _____</p> <p>AUTOMATIC CHECK WITHDRAWAL REQUEST: By selecting automatic check withdrawal, your United Wisconsin Life Insurance Company monthly premium will automatically be withdrawn from your checking account. Complete the form below and include a voided check with the Enrollment Form and the initial premium. To: _____ Address: _____</p>	<p>I request that you pay and charge my account debits drawn from my account by Health Plan Administrators, Inc. to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may at any time end this agreement by giving 30 days advanced written notice to me and to Health Plan Administrators, Inc. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.</p> <p>_____ Signature of Premium Payer _____ Date _____</p> <p>FOR AGENT'S USE ONLY Print Agent Name _____ Agent ID# _____ Street Address _____ City _____ State _____ Zip _____ Phone# () _____ Fax# () _____ E-Mail _____ Licensed Agent Signature _____</p>
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U.S. BENEFITS ASSOCIATION ENROLLMENT FORM

Please enroll me as a member of the U.S.B.A. My membership entitles me to all the money-saving U.S.B.A. benefits. I understand the membership fee of \$10.00 is due annually. This program is not affiliated with United Wisconsin Life Insurance Company.

Signature of Applicant: X _____ Date: _____

SIGNATURE REQUIRED/AUTHORIZATION
TO RELEASE MEDICAL INFORMATION FOR UNDERWRITING

Please clearly print all information.

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

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

Customer Signature X _____ Date _____

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

Spouse Signature X _____ Date _____

(if spouse is covered)

Signature of Each Covered Dependent Age 18 and over (to be Insured):

X _____ Date _____ X _____ Date _____

X _____ Date _____ X _____ Date _____

Short-Term Plan Monthly Premiums Effective 3/1/01

Underwritten by United Wisconsin Life Insurance Company
Administered by Health Plan Administrators, Inc.

Deductible per 12-month coverage period per insured																		
Area:	A	A	B	B	C	C	D	D	E	E	F	F	G	G	H	H	I	I
Age:	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
0-24	50	61	56	69	62	76	65	80	69	85	73	90	78	96	84	104	92	114
25-29	59	83	67	93	73	102	78	108	82	115	87	122	93	130	101	140	110	153
30-34	67	83	75	93	83	102	87	108	93	115	98	122	105	130	113	140	123	153
35-39	81	84	91	94	100	104	105	109	112	116	119	123	126	131	136	142	149	155
40-44	98	109	110	123	121	135	127	143	135	152	144	161	153	171	165	185	180	202
45-49	126	155	142	174	156	191	165	202	175	215	186	228	198	243	214	262	233	286
50-54	170	206	191	231	210	254	221	269	236	286	250	303	266	323	287	348	313	380
55-59	268	280	302	315	331	346	350	365	373	389	395	412	421	439	454	474	495	517
*Child	41	41	47	47	51	51	54	54	57	57	61	61	65	65	70	70	76	76

Deductible per 12-month coverage period per insured																		
Area:	A	A	B	B	C	C	D	D	E	E	F	F	G	G	H	H	I	I
Age:	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
0-24	42	52	48	59	52	65	55	68	59	73	62	77	66	82	72	89	78	97
25-29	50	70	57	79	62	87	66	92	70	98	74	103	79	110	85	119	93	130
30-34	57	70	64	79	70	87	74	92	79	98	84	103	89	110	96	119	105	130
35-39	68	71	77	80	85	88	89	93	95	99	101	105	107	112	116	121	126	131
40-44	83	93	93	104	102	115	108	121	115	129	122	137	130	146	140	157	153	171
45-49	107	132	121	148	133	163	140	172	149	183	158	194	168	206	182	223	198	243
50-54	144	175	162	197	178	216	188	228	200	243	212	257	226	274	244	296	266	323
55-59	228	238	256	268	282	294	298	311	317	330	336	350	358	373	386	403	421	439
*Child	35	35	40	40	43	43	46	46	49	49	52	52	55	55	60	60	65	65

Deductible per 12-month coverage period per insured																		
Area:	A	A	B	B	C	C	D	D	E	E	F	F	G	G	H	H	I	I
Age:	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
0-24	36	45	41	50	45	55	47	59	51	62	54	66	57	70	62	76	67	83
25-29	43	60	49	68	54	75	57	79	60	84	64	89	68	95	73	102	80	111
30-34	49	60	55	68	60	75	64	79	68	84	72	89	76	95	83	102	90	111
35-39	59	61	66	69	73	76	77	80	82	85	87	90	92	96	100	104	109	113
40-44	71	80	80	90	88	99	93	104	99	111	105	117	112	125	121	135	131	147
45-49	92	113	104	127	114	140	120	148	128	157	136	166	144	177	156	191	170	209
50-54	124	150	139	169	153	186	162	196	172	209	182	221	194	236	210	254	229	277
55-59	196	204	220	230	242	252	256	267	272	284	288	301	307	321	332	346	362	377
*Child	27	27	30	30	33	33	35	35	37	37	40	40	42	42	46	46	50	50

Deductible per 12-month coverage period per insured																		
Area:	A	A	B	B	C	C	D	D	E	E	F	F	G	G	H	H	I	I
Age:	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
0-24	29	36	33	40	36	44	38	47	40	50	43	52	45	56	49	60	53	66
25-29	34	48	39	54	43	59	45	63	48	67	51	71	54	75	58	81	64	89
30-34	39	48	44	54	48	59	51	63	54	67	57	71	61	75	66	81	72	89
35-39	47	49	53	55	58	60	61	63	65	67	69	71	73	76	79	82	86	90
40-44	57	63	64	71	70	78	74	83	79	88	83	93	89	99	96	107	104	117
45-49	73	90	82	101	90	111	96	117	102	125	108	132	115	141	124	152	135	166
50-54	98	119	111	134	122	147	128	156	137	166	145	176	154	187	167	202	182	220
55-59	156	162	175	183	192	201	203	212	216	225	229	239	244	255	263	275	287	300
*Child	21	21	24	24	26	26	28	28	29	29	31	31	33	33	36	36	39	39

How to Calculate Monthly Premium

- Choose your deductible. Indicate here:
 \$250 \$500 \$1000 \$2500
- Locate the state zip code of the applicant's resident address below. The letter listed to the right of the zip code is the AREA LETTER used to determine the premium.
- Using the premium chart, go to the section for the deductible you have chosen.
- Locate your AREA LETTER.
- Find your age (and spouse's age) on the monthly premium chart.
- Select the applicant's (and spouse's) gender.
- If you're applying for coverage of your dependent children, use the *child premium rate based on the gender of the youngest child.
- Carry this figure(s) into the calculation chart below.

Coinsurance Options:

The monthly premium rates shown are for:

Option A 80% of \$5,000

To calculate the monthly premium rates for:

Option B 50% of \$5,000

Multiply rate by premium factor .80

Rate Calculation:

Applicant's	\$	_____
Spouse's	\$	_____
Per Child \$_____ X#_____	\$	_____
FFI Rx Prescription Card (optional)	\$	3.50
Monthly Administration	\$	12.50
USBA Annual Dues (1st month only)	\$	10.00
Total Amount Due	\$	_____

How to Apply for Child(ren)-only Coverage

When applying for coverage ONLY on the child(ren), the minimum age is two years. Use the 0-24 premium rate (male or female, based on the gender of the youngest child). Then use this per-child rate for each child to be insured on the plan. The parent or legal guardian must sign and date the application.

About the U.S. Benefits Association

U.S. Benefits Association provides numerous quality benefits and discounts to its members. Your enrollment entitles you to money-saving discounts with Miracle Ear, Swanson Vitamins, Flowers USA, and Anheuser Busch Theme Parks. The \$10 membership fee is for an annual membership.

FFI Rx Prescription Drug Discount Card

Available with your USBA membership is the FFI Rx Drug Card by FFI Health Services. Its slogan is "affordable prescriptions for life." There are over 35,000 pharmacies that participate in this program, which offers members discounts up to 65% off retail cost of specific brand-name drugs. The savings on most other brand and generic drugs will average 20% to 60% off the normal retail cost. Monthly fee is \$3.50.

Complementing the FFI Rx retail program is the Wal-Mart Pharmacy Mail Service Program, offered through FFI Health Services. Members will pay the wholesale price minus 12 - 14% of brand-name and maximum allowable cost pricing for generic prescription drugs. Call toll free: 1-800-699-7857.

State Zip Code and Area Chart

<u>AR</u>	610-611, 615-616, 618, 627	C	166, 168, 183, 195-196	C	750-755, 762, 783-784	D
727-729	A	609, 620-622	D	157-158, 162-163, 167	D	770, 773-774, 776-777, 794
716-719, 724-726	B	600-606	G	169, 172, 177-179, 188	D	775
723	C	<u>NE</u>		161, 164-165, 170-171	E	<u>WI</u>
720-722	D	683-693	A	180-182	E	547, 549, 533, 538-539
<u>DC</u>		680-681	B	155-159	F	541-545
200, 202-205	F	<u>NM</u>		150-154, 156, 160	H	546, 548, 534-537
<u>DE</u>		875-880	B	189-194	I	540
199	D	870-874, 881-884	C	<u>TX</u>		530-532
197-198	E	<u>OK</u>		756, 765-767, 786-787, 797	A	<u>WV</u>
<u>IL</u>		735,740-741,749	A	757-759, 763-764, 768-769,	B	261-267
607, 612-614, 619, 623-624, A	A	730-731,734,736-739,743-748	B	771-772, 778-782, 785,	B	247-249, 252, 255-259, 268
626, 628-629	A	<u>PA</u>		788-793, 795-796	B	260
617, 625	B	173-176	A	760-761, 798-799	C	250-251, 253-254