American Alternative Insurance Corporation - Princeton, NJ
Short Term Medical PLUS Application - Virginia Only

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Short Term Medical <sup>™</sup>

PLUS

ADMIN. USE ONLY CASE # \_\_\_\_\_

			annig acciptionage		•		e						
1	You may re the month) received b See brochu	as long as the applica by Allied before the re- ure for details on effect	tive date (may be any c ation and premium are equested effective dat	B. PLAN OPTIONS: □ Monthly Billing Maximum Coverage Period: □ 6 Months □ 12 Months □ Prepay Plan – Number of Months (1 to 12) Optional Termination Date// Deductible: □ \$500 □ \$1,000 □ \$1,500 □ \$2,500 □ \$5,000 □ \$7,500 □ \$10,000 \$500 Supplemental Accident Option: □ YES □ NO □ Heat applications for Children to Children the Children to Children t									
	This coverage does not renew.									plication	instruct	ions	
		•	MIDDLE INITIAL, LAST NA	AME)				SOCIA	AL SECURITY NU	MBER			
	RESIDENCE	ADDRESS											
2	CITY		STATE					ZIP		DAYTIME TELEPH	HONE (In	clude Are	a Code)
	BILLING NA	ME/ADDRESS (IF DIFFE	RENT THAN ABOVE) PLE	ASE INCL	UDE FULL N								
	APPLICANT	'S DATE OF BIRTH	AGE	GEN	IDER	Spou	se – Must be	under ag		ge 65 (unless apply	/ing for ch	nild only co	overage)
	Comple		to Insure your s				dren						
	Spouse		Name, Middle Initial, Last Name)	D	ATE OF BIR	тн	AGE		GENDER		SOC.	SEC. NUI	MBER
2	Child #1												
J	Child #2												
	Child #3												
	Please ans	swer the following g	uestions completely a	nd accu	ratelv (anv	"YES	" answer n	neans	coverage cann	ot be issued):			
4	an exp B. Within injury) C. Are yo Overw D. Are yo Overw E. Within been r test re • 0 • 0 • 0 • 0 • 0 • 0 • 0 • 0 • 0 • 0	bectant father or in the the last five (5) years for four (4) consecutiv u or any Dependent to reight is any male over the last five (5) years ecommended to see a sults for, or been diag Alcohol Abuse, Alcoho Cancer or Tumor (exc Chronic Obstructive P Diabetes; Drgan or Tissue Trans Blood disorder – incluc Circulatory system disor Mental/Nervous Gisord the last twelve (12) m edical treatment, diag ersons to be insured a	ulmonary Disease, Cys	in the pr ndent to over 250 t AND be over 250 t AND be over 250 ndent to or receiv ollowing dency or tic Fibros emophilia nest pain t limited to Lupus, nited to F limited to tion Depend y that has s, pleass	ocess of sub be insured or diagnos o pounds en diagnos o pounds be insured ed diagnos conditions? Substance sis, Emphys a or leukem , heart failu to stroke o HIV, AIDs lepatitis, P Muscular I muscular I s not been of a answer "h	nrrogat been sed wit seed wit seed wit seed wit seed wit seena, hia; rr deep or AR olycys Dystro comple comple comple vor to t	e pregnanc nospital cor h high blood or been tre- ting, or rece ; Pulmonary thm disturb vein thromi C; tic Kidney E phy; or been advise ted? his question	ry? offined for d press choleste ated by ated by eived m Embolis bosis/pl Disease ed by a n. If any	or any reason (c ure (whether or erol (whether or any medical pr edication, or rec sm or Tuberculo or heart attack; hlebitis (does no or Renal Failur ny medical prof	other than bodily not treated or co ofessional, or ceived abnormal osis; ot include high bl e; essional to have	ontrolled	<ul> <li>YES</li> <li>YES</li> <li>YES</li> <li>YES</li> <li>YES</li> </ul>	□ NO □ NO □ NO □ NO
5	misreprese This is not Pre-Existin enrolling as Insurance ( The unders any false s incomplete of insurance I authorize requesting and physic insurance o purpose of in writing a authorizatic as the origi	entation or omission, m a continuation of any g Condition (refer to th s a member of the set Corporation's only obl signed applicant and a tatement or misrepres or misleading informa- te benefits. the disclosure of all n dependent coverage) al or mental conditions company, employer or approving enrollment t any time; that I may pn; that this authorizat inal; and that I have au	following: (a) Any inco naterial to and in this ap previous medical plan, he plan brochure and co lor of Allied Group Insu- gation will be to return gent certify that the applicat tition to an insurance co onpublic personal inform, including but not limite s (including alcohol or of benefit plan having su and processing claims request a copy of this a ion will be used as its of thority to act as the pe	polication including ertificate irrance Tr any prem oblicant ha ion may r mpany for mation ar ad to emp frug depe ch inform I acknov uthorizat wn docu rsonal re	, may result any prior to of insurance ust; (e) If the isum paid; a sesult in los or the purport ad individua bloyment st ndency), b ation, to the wledge and ion; that em ment, sepa presentative	t in res empor e for c he appl and (f) had re s of c bse of ally ide atus, c by any e Insul agree l agree rate from re of m	scission of ti ary health in omplete exy ication is de 1 received a ad to him, ti verage unc defrauding ntifiable pro- tifiable	he insu nsuranc planatic eclined and rev he com der the p the com betected nce cov medical pany or uthoriza porocess lication; ht(s) (if	rance contract a ce plan; (c) This pon); (d) By apply and coverage is iewed the plan I pleted application policy. It is a crim npany. Penalties health informatii verage, diagnosis practitioner, ho its legal representioner, ho its legal representioner, and its of claims ar ; that a photocop requesting dependent	and/or denial of ir insurance will nc ing for this insur; s not issued, Amo prochure. on and that the a me to knowingly j s include impriso on for me (and m is, prognosis, me spital, other med entative, agent o ild for two (2) yea e not conditioned by of this authoriz- endent coverage)	nsurance of pay be ance coordinate erican A applicant provide nment, f ny deper- edical trel lical relat r vendor ars; that d on my zation sl ).	e benefit enefits fo verage I Ilternative realizes false, fines and ted facili , for the I may re signing I hall be a	is; (b) or any am e that d denial if or care ty, vvoke it this s valid
	STM 2006-	-1.IA (VA)	Underwritte	en by Am	erican Alte	rnative	Insurance	Corpor	ation	Po	DICY For	m #STM	2006-1

TM 2006-1.IA (VA)	Underwritten by American Alternative Insurance Corporation	Policy Form #STM 2006-1
MAIL TO: ALLIED NAT	IONAL • UNDERWRITING • P.O. BOX 29187 • SHAWNEE MISSION, KS 66201-9187	3207s0114
	www.alliednational.com • 800-825-7531	





## Short Term Medical PLUS Rate Calculation Worksheet

The rate calculation worksheet below makes it easy to calculate the rates you pay for Allied's Short Term Medical Plus. Using different combinations of deductibles and durations you can find the plan that works best for you and your budget.

10/1/14 - 12/31/14

#### RATE CALCULATION:

- Determine rates based on deductible chosen and sex and age of each person. For child(ren) rate multiply number of children by the per child rate.
- 2) Multiply the subtotal (D) of these rates by the Area Factor, the Rate Load Factor and the Duration Factor to get Premium Subtotal (E) and round to nearest dollar. The Rate Load Factor is determined by the requested effective date and whether choosing Prepay or Monthly billing.
- The duration factor is determined by the maximum length of coverage requested and the age of the applicant.
- 4) Add rates for optional Supplemental Accident coverage if applicable. Supplemental Accident rate is for each person applying (e.g. if applicant, spouse and 1 child apply, the rate is 3 times \$5 for a rate of \$15).
- 5) Add Administration Fee to get Total Monthly Cost (H).
- 6) For Prepay ONLY multiply H times number of months requested for Prepay total Cost (J).

NOTE- Business checks cannot be accepted. Payment must be made by credit card or personal check payable to Allied National.

# Online enrollment and rating is available at *tempmedsales.alliednational.com*.

RATE LOAD FACTORS						
BILLING MODE	PREPAY	MONTHLY				
1/1/14 – 3/31/14	1.00	1.33				
4/1/14 - 6/30/14	1.03	1.37				
7/1/14 - 9/30/14	1.06	1.41				

1.09

1.45

#### DURATION FACTORS

ION I AC	
6 MONTH	12 MONTH
1	1.2
1	1.23
1	1.26
1	1.29
1	1.31
1	1.34
1	1.37
1	1.4
	6 MONTH 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1

A. Applicant	\$_	
B. Spouse	+\$ _	
C. Child(ren)	+\$ _	
D. Subtotal	=\$ _	
Area Factor		
Load Factor	Χ_	
Duration Factor		
E. Premium Subtotal		
(round to nearest \$)	=\$ _	
F. Supp.Acc.Option	+\$_	
G. Administration Fee	+\$	12.00
H. Total Monthly Cost	=\$ _	
PREPAY I	PLAN	ONLY
I. Number of Months	Χ_	
J. Prepay Total Cost	=\$ _	

### AREA RATING FACTORS (based on first 3 digits of zip code of the residence address)

Alaska:	304-305, 307, 310-311,	Missouri:	732-734, 735-739	Virginia*:
995-999	315-319, 3981.40	630-631, 633, 640-641 1.60	742-7491.40	222-2231.90
Arkansas:	Illinois:	6451.50	Oregon:	220-221, 2011.70
716, 717, 719-723, 725 1.60	6062.20	634-639, 642, 644, 646-658 1.30	972, 973, 975 - 9771.50	224-231, 232-239, 240-2461.40
718, 724, 726-729 1.50	600, 602-6051.90	Nebraska:	970, 971, 974, 978, 9791.40	West Virginia:
Colorado* :	601, 607-6081.70	680-6811.30	Pennsylvania:	253, 2601.60
800-806 1.50	609,614-615, 620-6221.40	682-6931.20	150-152, 189, 192-1941.80	251-252, 254-2571.50
807-816 1.40	610-613, 616-619, 623-6291.30	Nevada 🔶:	153-188, 195-196,1.60	247-250, 258-259, 261-2681.40
Delaware:	Indiana ♦:	889, 890, 891, 893, 895, 897,	190-1912.00	Wisconsin:
1981.70	463-4641.70	8981.90	Rhode Island:1.50	5321.60
197 & 199 1.60	462, 465-4661.40	New Mexico:	South Carolina:1.50	531, 540, 543, 5481.50
District Of Columbia*	460-461, 467-4791.30	870-875, 877-8841.40	Tennessee:	535, 537-539, 541, 542,
200, 202-205	lowa:	North Carolina:	380-3821.60	544-547, 5491.40
Florida*: 330-332	500-5031.40	270-276, 280-2821.40	371-3741.50	530, 5341.30
330-332	504-508, 510-516, 520-5291.20	277-279, 283-2891.30	370, 377-379, 383-3851.40	Wyoming 4: 820-8311.40
334	Maryland:	Ohio ♦:	3761.30	
322, 335-336	210-212, 214,215, 2181.50	440-4411.60	Texas*:	*These states require the use of a state
320, 321, 327-328, 337, 339,	206, 208, 216, 217, 2191.40	436, 444-4451.50	770-7722.00	specific application form.
341-342, 346-347, 349 1.80	207, 2091.30	433-435, 437-439, 442-443,	773-7751.90	
326, 329, 338, 344 1.60	Michigan:	446-447, 449, 452-453 1.40	750-753, 776-7771.70	
323-325 1.50	480-483	430-432, 448, 450-451,	760-7611.60	in: CO, IN, NV, OH, WY
Georgia:	488-489	454-458	762-764, 7971.50	
300-303 1.70	484, 485, 490-492, 497-499 1.40	Oklahoma*:	754-759, 765-769, 778-796,	
306, 313-3141.60	486, 487, 493-4961.30		798-7991.40	
308-309, 312 1.50				

#### **RATES/AREAS EFFECTIVE 1/01/14**

\$500	Deduc	tible	\$1,00	0 Dedu	uctible	\$1,50	0 Dedu	uctible	\$2,50	0 Dedu	uctible	\$5,00	0 Dedu	uctible	\$7,50	0 Dedu	uctible	\$10,00	0 Ded	uctible
Age	Male	Fem.	Age	Male	Fem.	Age	Male	Fem.	Age	Male	Fem.	Age	Male	Fem.	Age	Male	Fem.	Age	Male	Fem.
0-29	\$49	\$61	0-29	\$43	\$51	0-29	\$35	\$41	0-29	\$26	\$32	0-29	\$22	\$25	0-29	\$18	\$23	0-29	\$17	\$21
30-34	\$58	\$75	30-34	\$48	\$63	30-34	\$39	\$52	30-34	\$32	\$40	30-34	\$25	\$32	30-34	\$22	\$29	30-34	\$20	\$25
35-39	\$71	\$90	35-39	\$61	\$76	35-39	\$48	\$62	35-39	\$39	\$49	35-39	\$31	\$39	35-39	\$26	\$35	35-39	\$25	\$31
40-44	\$86	\$107	40-44	\$74	\$90	40-44	\$60	\$74	40-44	\$47	\$58	40-44	\$37	\$46	40-44	\$32	\$40	40-44	\$30	\$37
45-49	\$107	\$121	45-49	\$90	\$104	45-49	\$74	\$83	45-49	\$58	\$66	45-49	\$46	\$53	45-49	\$40	\$47	45-49	\$37	\$41
50-54	\$137	\$147	50-54	\$116	\$125	50-54	\$94	\$101	50-54	\$75	\$81	50-54	\$59	\$63	50-54	\$53	\$56	50-54	\$47	\$51
55-59	\$192	\$178	55-59	\$163	\$151	55-59	\$132	\$122	55-59	\$105	\$98	55-59	\$83	\$76	55-59	\$74	\$68	55-59	\$66	\$61
60-64	\$261	\$239	60-64	\$221	\$202	60-64	\$179	\$164	60-64	\$141	\$130	60-64	\$112	\$104	60-64	\$99	\$91	60-64	\$90	\$82
Per Cl	hild	\$43	Per C	hild	\$37	Per Cl	hild	\$30	Per C	hild	\$24	Per C	hild	\$18	Per C	hild	\$17	Per Cł	nild	\$15
	Complemental Applicate Data Data Descent fr																			

Supplemental Accident Rate Per Person \$5

AP	PLYING FOR COVERAGE - PAPER APPLICATION
1)	Fill out the application completely. Check the boxes for monthly or prepay payment and deductible options. Select an effective date (write in ASAP for the earliest date you qualify for), and optional termination date. For prepay plan only, choose the total number of months (1 to 12 months – the 12-month coverage option is limited to 364 days). Select your maximum desired coverage period of six or 12 months. Agent MUST complete the AGENT INFO section below. The application MUST be signed by the applicant. Any application not signed will be declined.
2)	Calculate the monthly premium using the Allied online rating and enrollment website at www.alliednational.com/sales.
3)	For the prepay option, payment by check or credit card for the entire duration of coverage must be submitted. For the monthly bill option, the first month's premium can be paid by check or credit card. For the monthly bill plan, premiums after the first month will be billed to the applicant. <b>Pre-authorized</b> check or credit card payment plans may be elected by filling out the authorization agreement below.
	<b>IMPORTANT NOTE:</b> No employer or business involvement is allowed on Allied Short Term Medical PLUS. Company or business checks will not be accepted. Payment must be made using a personal check or credit card.
4)	Applications may be mailed or faxed to Allied National. Submit the completed and signed application, total premium due (made payable to Allied National) and a copy of the agent's license to: Allied National
	Underwriting Department
	P. O. Box 29187
	Shawnee Mission, KS 66201-9187
I aut once unde my c	TIONAL AUTHORIZATION AGREEMENT FOR AUTOMATIC MONTHLY PREMIUM PAYMENTS horize Allied National to charge my account as indicated below for my monthly insurance premium and fees. I understand my account will be charged e each month for the total amount shown as due on my monthly premium statement for the limited term of the policy of insurance issued to me. I erstand that if a charge to my account is not honored, my insurance coverage could lapse prior to its termination date. I understand that if I wish to cancel coverage prior to its termination date, I must inform Allied National of such cancellation prior to the end of the grace period corresponding to the date of cellation. Please charge my monthly premium and fees against the following account.
NAN	IE (as shown on account – please print)
	CREDIT CARD: MasterCard Visa – Account NumberExpiration DateExpiration Date
	□ CHECKING/NOW ACCOUNT: Please attach a voided check from the account you wish billed for your coverage.
:	SIGNATURE DATE

	SOLICITING AGENT'S SIGNATURE		DATE
NO	Soliciting Agent's Name	Agency	Allied Agent#
ATI	Address	City	State Zip
RM	Tel ( )	Pay Commissions to:	SS# or Tax ID#
РŌ	Fax ( )	EMAIL	
ž	1) Is the soliciting agent a licensed agen	t in the applicant's state of residence?	
F	□ Yes – If Yes, please send copy of state	license.  No - If No, the agent is not authorized to s	olicit this coverage and the policy cannot be issued.
ĒN	2) Is the soliciting agent currently appoint	nted with American Alternative Insurance Corpora	tion:
G	Direct with American Alternative Insuran	nce Corporation? Or  Through ALLIED or another A	dministrator? WHO?
۷	Appointment fees: Allied National will pay	fee for agent appointment.	
	DISTRIBUTOR/GENERAL AGENT NAME	:	

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To calculate rates for all available plan options, go to Allied's online rating system at:

#### www.alliednational.com/sales

**IMPORTANT NOTICE:** Short-term medical products do *not* meet the Affordable Care Act's definition of minimum essential coverage and therefore do *not* fulfill an individual's requirement to maintain coverage.