Short Term Medical℠ PLUS

American Alternative Insurance Corporation Princeton, NJ

Short Term Medical PLUS Application – Colorado Only

When mailing use postage stamp only – No postage meter

ADMIN. USE ONLY
CASE # _____

The Policy does not provide portability of prior coverage. As a result, any injury, sickness, or pregnancy for which you have incurred charges, received medical treatment, consulted a health care professional, or taken prescription drugs within 12 months of the effective date of the policy will not be covered under the Policy.

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A. Requested Effective Date _____/_____/_____
You may request a specific effective date (may be any day of the month) as long as the application and premium are **received by Allied before the requested effective date**. See brochure for details on effective dates.

This coverage does not renew.

B. PLAN OPTIONS: ☐ Monthly Billing
Maximum Coverage Period: ❑ 6 Months
☐ Prepay Plan – Number of Months (1 to 6)_____
Optional Termination Date _____/_____/_____
Deductible: ☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000
$500 Supplemental Accident Option: ☐ YES ☐ NO
☐ I am applying for Child Only coverage – see brochure for application instructions

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APPLICANT'S NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)	SOCIAL SECURITY NUMBER
RESIDENCE ADDRESS	
CITY / STATE / ZIP / DAYTIME TELEPHONE (Include Area Code)	
BILLING NAME/ADDRESS (IF DIFFERENT THAN ABOVE) PLEASE INCLUDE FULL MAILING ADDRESS AND PHONE NUMBER	

APPLICANT'S DATE OF BIRTH	AGE	GENDER	Applicant – Must be over age 17 and under age 65 (unless applying for child only coverage) Spouse – Must be under age 65 Dependent Children – Must be under age 19

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Complete this section to insure your spouse and/or children

	FULL NAME (First Name, Middle Initial, Last Name)	DATE OF BIRTH	AGE	GENDER		SOC. SEC. NUMBER
Spouse						
Child #1						
Child #2						
Child #3						

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Please answer the following questions completely and accurately (any "YES" answer means coverage cannot be issued):

A. Are you over age 64, or is your Dependent Spouse to be insured over age 64, or is any Dependent Child to be insured over age 18? ❑ YES ❑ NO

B. Are you or any Dependent to be insured covered under other hospital, major medical, group health or other medical insurance coverage? ❑ YES ❑ NO

C. Are you or any Dependent to be insured a member of the armed forces of any country, state or international organization, other than on reserve duty for 30 days or less? ❑ YES ❑ NO

D. Are you or any Dependent to be insured currently pregnant, or if insuring dependents, are you an expectant father or planning on adopting? ❑ YES ❑ NO

E. Within the last five (5) years, have you or any Dependent to be covered been hospital confined for five (5) consecutive days or longer? ❑ YES ❑ NO

F. Are you or any Dependent to be insured overweight AND been diagnosed with high blood pressure (whether or not treated or controlled)? Overweight is any male over 300 pounds or female over 250 pounds. ❑ YES ❑ NO

G. Are you or any Dependent to be insured overweight AND been diagnosed with elevated cholesterol (whether or not treated or controlled)? Overweight is any male over 300 pounds or female over 250 pounds. ❑ YES ❑ NO

H. Within the last five (5) years, have you or any Dependent to be covered seen any medical professional, been recommended to see a medical professional, been treated, received medication or received abnormal test results for, or been diagnosed with, any of the following conditions?
- Cancer (excluding basal cell), Diabetes, Hepatitis, Liver Disorder, Polycystic Kidney Disease, Renal Failure, AIDs or tested positive for HIV (WI applicants do not need to disclose HIV test results);
- Heart disorder – including but not limited to chest pain, heart failure, rhythm disturbances or heart attack;
- Circulatory system disorder – including but not limited to stroke or deep vein thrombosis/phlebitis (does not include high blood pressure);
- Nervous System disorder – including but not limited to Muscular Dystrophy; or
- Mental/Nervous disorder, Substance Abuse or Alcoholism requiring hospitalization. ❑ YES ❑ NO

I. If all persons to be insured are United States citizens, please answer "No" to this question. If any person to be insured is not a United States citizen, has that person resided outside the United States at any time over the last 24 months? ❑ YES ❑ NO

J. Have you or any other person to be insured been covered under two or more individual Short-Term policies during the past 12 months? ❑ YES ❑ NO
If "Yes", then this policy may not be issued. You must wait 6 months from the date of your last such policy to apply for a Short-Term policy.

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I understand or acknowledge the following: (a) This is not a continuation of any previous medical plan, including any prior temporary health insurance plan; (b) If the application is declined and coverage is not issued, American Alternative Insurance Corporation's only obligation will be to return any premium paid; and (c) I received and reviewed the plan brochure, which serves as an outline of coverage.

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 Colorado Division of Insurance within the Department of Regulatory Agencies.

I authorize the disclosure of all nonpublic personal information and individually identifiable protected health information for me (and my dependent(s), if requesting dependent coverage), including but not limited to employment status, other insurance coverage, diagnosis, prognosis, medical treatment or care and physical or mental conditions (including alcohol or drug dependency), by any physician, medical practitioner, hospital, other medical related facility, insurance company, employer or benefit plan having such information, to the Insurance Company or its legal representative, agent or vendor, for the purpose of approving enrollment and processing claims. I acknowledge and agree that this authorization shall be valid for two (2) years; that I may revoke it in writing at any time; that I may request a copy of this authorization; that enrollment and the processing of claims are not conditioned on my signing this authorization; that this authorization will be used as its own document, separate from the application; that a photocopy of this authorization shall be as valid as the original; and that I have authority to act as the personal representative of my dependent(s) (if requesting dependent coverage).

Applicant's Signature _____ Date _____

STM 2006-2.IA (CO) Underwritten by American Alternative Insurance Corporation Policy Form #STM 2006-2

Colorado law requires carriers to make available a Colorado Health Benefit Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within 3 business days to a potential policyholder who has expressed interest in a particular plan or who has selected the plan as a finalist from which the ultimate selection will be made. The carrier also must provide the form, upon oral or written request, within 3 business days, to any person who is interested in coverage under or who is covered by a health benefit plan of a carrier.

Short Term Medical PLUS℠

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.

RATE CALCULATION:

1) 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.
3) 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
10/1/14 – 12/31/14	1.09	1.45

DURATION FACTORS

AGE	6 MONTH	12 MONTH
0 – 29	1	1.2
30 – 34	1	1.23
35 – 39	1	1.26
40 – 44	1	1.29
45 – 49	1	1.31
50 – 54	1	1.34
55 – 59	1	1.37
60 – 64	1	1.4

A. Applicant $ _____
B. Spouse +$ _____
C. Child(ren) +$ _____
D. Subtotal =$ _____
Area Factor X _____
Load Factor X _____
Duration Factor X _____
E. Premium Subtotal (round to nearest $) =$ _____
F. Supp.Acc.Option +$ _____
G. Administration Fee +$ **12.00**
H. Total Monthly Cost =$ _____

PREPAY PLAN ONLY

I. Number of Months X _____
J. Prepay Total Cost =$ _____

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

Alaska:
995-999 ... 2.00
Arkansas:
716, 717, 719-723, 725 ... 1.60
718, 724, 726-729 ... 1.50
Colorado*◆:
800-806 ... 1.50
807-816 ... 1.40
Delaware:
198 ... 1.70
197 & 199 ... 1.60
District Of Columbia*
200, 202-205 ... 2.20
Florida*:
330-332 ... 3.50
333 ... 2.90
334 ... 2.50
322, 335-336 ... 2.00
320, 321, 327-328, 337, 339, 341-342, 346-347, 349 ... 1.80
326, 329, 338, 344 ... 1.60
323-325 ... 1.50
Georgia:
300-303 ... 1.70
306, 313-314 ... 1.60
308-309, 312 ... 1.50
304-305, 307, 310-311, 315-319, 398 ... 1.40
Illinois:
606 ... 2.20
600, 602-605 ... 1.90
601, 607-608 ... 1.70
609,614-615, 620-622 ... 1.40
610-613, 616-619, 623-629 ... 1.30
Indiana ◆:
463-464 ... 1.70
462, 465-466 ... 1.40
460-461, 467-479 ... 1.30
Iowa:
500-503 ... 1.40
504-508, 510-516, 520-529 ... 1.20
Maryland:
210-212, 214,215, 218 ... 1.50
206, 208, 216, 217, 219 ... 1.40
207, 209 ... 1.30
Michigan:
480-483 ... 1.60
488-489 ... 1.50
484, 485, 490-492, 497-499 ... 1.40
486, 487, 493-496 ... 1.30
Missouri:
630-631, 633, 640-641 ... 1.60
645 ... 1.50
634-639, 642, 644, 646-658 ... 1.30
Nebraska:
680-681 ... 1.30
682-693 ... 1.20
Nevada ◆:
889, 890, 891, 893, 895, 897, 898 ... 1.90
New Mexico:
870-875, 877-884 ... 1.40
North Carolina:
270-276, 280-282 ... 1.40
277-279, 283-289 ... 1.30
Ohio ◆:
440-441 ... 1.60
436, 444-445 ... 1.50
433-435, 437-439, 442-443, 446-447, 449, 452-453 ... 1.40
430-432, 448, 450-451, 454-458 ... 1.30
Oklahoma*:
730-731, 740-741 ... 1.50
732-734, 735-739 742-749 ... 1.40
Oregon:
972, 973, 975 - 977 ... 1.50
970, 971, 974, 978, 979 ... 1.40
Pennsylvania:
150-152, 189, 192-194 ... 1.80
153-188, 195-196, ... 1.60
190-191 ... 2.00
Rhode Island: ... 1.50
South Carolina: ... 1.50
Tennessee:
380-382 ... 1.60
371-374 ... 1.50
370, 377-379, 383-385 ... 1.40
376 ... 1.30
Texas*:
770-772 ... 2.00
773-775 ... 1.90
750-753, 776-777 ... 1.70
760-761 ... 1.60
762-764, 797 ... 1.50
754-759, 765-769, 778-796, 798-799 ... 1.40
Virginia*:
222-223 ... 1.90
220-221, 201 ... 1.70
224-231, 232-239, 240-246 ... 1.40
West Virginia:
253, 260 ... 1.60
251-252, 254-257 ... 1.50
247-250, 258-259, 261-268 ... 1.40
Wisconsin:
532 ... 1.60
531, 540, 543, 548 ... 1.50
535, 537-539, 541, 542, 544-547, 549 ... 1.40
530, 534 ... 1.30
Wyoming ◆: 820-831 ... 1.40

*These states require the use of a state specific application form.

◆ NOTE: 12 month coverage not available in: CO, IN, NV, OH, WY

RATES/AREAS EFFECTIVE 1/01/14

$500 Deductible			$1,000 Deductible			$1,500 Deductible			$2,500 Deductible			$5,000 Deductible			$7,500 Deductible			$10,000 Deductible		
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 Child		$43	Per Child		$37	Per Child		$30	Per Child		$24	Per Child		$18	Per Child		$17	Per Child		$15

Supplemental Accident Rate Per Person $5

For questions or assistance please call 1-800-825-7531

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APPLYING 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 6 months). Select your maximum desired coverage period of one to six 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.
Pre-authorized check or credit card payment plans may be elected by filling out the authorization agreement below.
IMPORTANT NOTE: 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

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OPTIONAL AUTHORIZATION AGREEMENT FOR AUTOMATIC MONTHLY PREMIUM PAYMENTS

I authorize Allied National to charge my account as indicated below for my monthly insurance premium and fees. I understand my account will be charged once 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 understand 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 my 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 cancellation. Please charge my monthly premium and fees against the following account.

NAME (as shown on account – please print) _____

☐ CREDIT CARD: ☐ MasterCard ☐ Visa – Account Number _____ Expiration Date _____

☐ CHECKING/NOW ACCOUNT: Please attach a voided check from the account you wish billed for your coverage.

SIGNATURE _____ DATE _____

AGENT INFORMATION

SOLICITING AGENT'S SIGNATURE _____ DATE _____

Soliciting Agent's Name _____ Agency _____ Allied Agent# _____

Address _____ City _____ State _____ Zip _____

Tel ( ) _____ Pay Commissions to: _____ SS# or Tax ID# _____

Fax ( ) _____ EMAIL _____

1) Is the soliciting agent a licensed agent in the applicant's state of residence?
☐ Yes – If Yes, please send copy of state license. ☐ No – If No, the agent is not authorized to solicit this coverage and the policy cannot be issued.

2) Is the soliciting agent currently appointed with American Alternative Insurance Corporation:
☐ Direct with American Alternative Insurance Corporation? Or ☐ Through ALLIED or another Administrator? WHO? _____

Appointment fees: Allied National will pay fee for agent appointment.

DISTRIBUTOR/GENERAL AGENT NAME:

RATES

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.