

Iowa Insurance Store

Application Instructions For American Community

1. Print all pages of the application including instructions.
2. Complete all questions and sections of the application.
3. Complete the fax cover letter on the next page and fax to Iowa Insurance Store for review along with the completed application. If you do not have access to a fax machine, send the completed application to Iowa Insurance Store along with the required first month's payment.

HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Indicate your requested effective date.
- Select your preferred billing method.
- Sign and date the application.

IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also complete, sign, and date the authorization form.

Mail completed application and check to:

Iowa Insurance Store
c/o Ginny Taylor
464 Tyler Drive
Pleasant Hill, IA 50327

Please contact us if you have any questions regarding the application or the application process. You may reach us at 515-285-4455 or e-mail us at James@IowaInsuranceStore.com.

Iowa Insurance Store

Application Process FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

****Please FAX this cover letter with the completed application to:**

Iowa Insurance Store

FAX# 515-974-8481

Dear Iowa Insurance Store,

Please accept my completed insurance application for submittal and contact me to confirm receipt of this application

Name _____

E-mail _____

Date _____

Time _____



Time _____

_____ after you have reviewed my application for completeness and accuracy.



I will contact Iowa Insurance Store at 515-285-4455 to verify receipt of my application.

****I understand that Iowa Insurance Store will not review this application until the following business day if I faxed this application after 5:00PM or on a weekend**

I understand that the original signed application must still be mailed to Iowa Insurance Store. I will mail the original signed application to :

**Iowa Insurance Store
c/o Ginny Taylor
464 Tyler Drive
Pleasant Hill, IA 50327**

I will send the original application as soon as I have been contacted by Iowa Insurance Store with confirmation that my application has been received by fax and reviewed for completeness.

IA Application

for Non-Renewable Short Term Medical Expense Policy

For Home Office Use Only
 Policy No. _____

For applicants less than 64 years of age. If children are to be insured, include all children, stepchildren and children adopted or placed for adoption of the applicant, who are dependent on the applicant and at least 15 days old, but have not reached their 22nd birthday.
PLEASE PRINT IN BLACK INK.

Key Applicant Full Name	Sex	Date of Birth	Social Security Number
Spouse	Sex	Date of Birth	Social Security Number
Dependent	Sex	Date of Birth	Social Security Number
Dependent	Sex	Date of Birth	Social Security Number
Dependent	Sex	Date of Birth	Social Security Number
Resident Address			
City, State, Zip Code			County
Resident Phone Numbers		REQUESTED EFFECTIVE DATE	
Daytime: ()	Evening: ()	<input type="checkbox"/> Day After Postmark <input type="checkbox"/> Specific Date ____/____/____	

QUESTIONS APPLY TO EACH PERSON PROPOSED FOR INSURANCE. IF ANY OF THE FOLLOWING QUESTIONS ARE ANSWERED "YES", SUCH PERSON IS INELIGIBLE FOR THE POLICY.

If "yes", who: _____

1. Have you, or any person to be insured, lived in a country outside the United States within the past 12 months? Yes No _____
2. Is any person to be insured now pregnant, an expectant father or planning to adopt a child during the term of this policy? Yes No _____
3. Has any person to be insured been recommended to seek treatment or do they have symptoms or conditions for which they intend to seek medical advice? Yes No _____
4. Has anyone to be insured had a Blood Pressure reading that exceeded 140/90 in the past 12 months? Yes No _____
5. Within the last five years, have you, your spouse or any dependent to be insured, been diagnosed or received any medical treatment for the following: Yes No _____
 - Heart disorder (such as chest pain, heart attack, irregular heart beat)
 - Blood disorders
 - Kidney disorder
 - Hepatitis
 - Chronic respiratory conditions
 - Central nervous system disorders
 - Diabetes
 - Cancer or tumors
 - Stroke
 - Rheumatoid arthritis
 - Alcohol, drug, or chemical abuse or dependency
 - Liver disorder
 - HIV/AIDS

I have read this application and represent that the information shown on it is true and complete to the best of my knowledge and belief. I understand and agree that:

1. The effective date of coverage can be no earlier than the day after the postmark date or, if not mailed, the date after the application is received at the Home Office of American Community Mutual Insurance Company.
2. No benefits are payable for a pre-existing condition as described in the policy.
3. Each person named in questions 1 through 5 is excluded from coverage under this policy.
4. No other Hospital, Major Medical, Group Health, or Medical Insurance coverage is in force on the effective date of this coverage.
5. The policy I am applying for is not a renewal or extension of any previous coverage and does NOT cover any condition for which benefits were paid under a previous policy.
6. I acknowledge that I have been provided with a Notice of Your Privacy Rights.
7. I have received a copy of the Outline of Coverage for the policy.

THIS IS LIMITED COVERAGE. PRE-EXISTING CONDITIONS ARE NOT COVERED. ALTERED APPLICATIONS WILL NOT BE ACCEPTED.

X _____ Date _____ X _____ Date _____
Signature Key Applicant Spouse's Signature
(or if minor Child, Parent or Guardian)

AGENT INFORMATION: Name: James A. Taylor, Jr. Number: 03388
Phone # 515-285-4455 Fax # 515-974-8481 Signature: X *James A. Taylor Jr.*

FRAUD WARNING: Any person, who with intent to defraud, or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. Any false statement or misrepresentation may result in the loss of coverage under this policy.

INITIAL PREMIUM PAYMENT OPTIONS: (make check or money order payable to American Community Mutual Insurance Company)

\$ _____ Credit Card Check Money Order

INITIAL PREMIUM SHORTAGE OPTIONS:

Credit Card Please complete Credit Card information if you have selected it as a Premium Payment Option.

CREDIT CARD (for initial payment only)

MasterCard Card Holder Name: _____
 Visa Card Number: _____ Expiration Date: _____
Signature: X _____ Date signed: _____

BILLING MODE:

Monthly Lump Sum

BILLING OPTIONS:

Bill Me EFT (Electronic Fund Transfer)

ELECTRONIC FUNDS

TRANSFER (EFT)

Checking
 Savings

Returned Check Fee: If any premium payment made directly by check or by Electronic Funds Transfer (EFT) is returned for non-sufficient funds, a nonrefundable service fee will be charged.

Name of Financial Institution: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Account Holder's Name: _____
Transit Routing Number: _____ Account Number: _____

Authorization Agreement For Electronic Funds Transfer for Premium Payment

I authorize American Community Mutual Insurance Company (Company) to initiate monthly electronic withdrawals, in the amount of the then-current monthly premium rate, from the account and financial institution (Bank) named above. This authority remains in effect until Company and Bank receives written notification from me of its termination in such time and manner as to give Company and Bank a reasonable opportunity to act on it. Company reserves the right to void this agreement at any time without prior notice.

Signature: X _____ Date Signed: _____

RATES EFFECTIVE JANUARY 1, 2007. Rates subject to change for policies issued with effective dates of January 1, 2008 and after.

1 80/20 BENEFIT PERCENTAGE									1 50/50 BENEFIT PERCENTAGE									2 COUNTY		AREA FACTOR
Age	\$250 Ded.		\$500 Ded.		\$1,000 Ded.		\$2,500 Ded.		Age	\$250 Ded.		\$500 Ded.		\$1,000 Ded.		\$2,500 Ded.		County	Area Factor	
	M	F	M	F	M	F	M	F		M	F	M	F	M	F	M	F			
18-24	73	106	53	79	35	53	25	39	18-24	55	80	40	59	26	40	19	29	Johnson	1.16	
25-29	78	122	57	92	38	62	28	47	25-29	59	92	43	69	29	47	21	35	Black Hawk	1.10	
30-34	79	128	58	97	39	66	29	50	30-34	59	96	44	73	29	50	22	38	Dallas, Dubuque, Jasper, Madison, Marion, Polk, Warren, Woodbury	1.05	
35-39	94	153	70	117	47	80	34	61	35-39	71	115	53	88	35	60	26	46	Rest of State	1.00	
40-44	118	173	88	132	59	91	43	70	40-44	89	130	66	99	44	68	32	53			
45-49	157	192	119	148	80	101	60	78	45-49	118	144	89	111	60	76	45	59			
50-54	199	211	152	162	103	111	79	86	50-54	149	158	114	122	77	83	59	65			
55-59	265	252	205	195	141	134	111	106	55-59	199	189	154	146	106	101	83	80			
60-63	328	287	256	223	178	154	143	122	60-63	246	215	192	167	134	116	107	92			
Child	63	63	45	45	28	28	20	20	Child	47	47	34	34	21	21	15	15			

PLAN CHOSEN:

Deductible: \$250 \$500 \$1,000 \$2,500 **Coinsurance:** 80/20 of \$5,000 50/50 of \$5,000

TERM OF INSURANCE:

1 Month 2 Months 3 Months 4 Months 5 Months 6 Months

PREMIUM CALCULATIONS: (figure health premium at age last birthday.)

	Male	Female	Child/Children	Total
1 Base Rate	_____	_____	_____	= _____
			2 Area Factor	x _____ = _____
			3 Premium Mode	x _____ = _____
			Monthly Premium	= _____

All key applicants under the age of 18 will pay the male age 18-24 rate. Dependents age 18 or older pay adult rates. Dependent children ages 15 days through 17 years pay the child rate for the first 3 children. No charge for additional children under age 18.

To calculate EFT or monthly payment options, multiply the monthly premium by the modal factor. To calculate the lump sum payment, multiply the monthly premium by the number of months of coverage.

3 PREMIUM MODES	MODAL FACTOR
Lump Sum Payment	1.00
Electronic Funds Transfer (EFT)	1.05
Monthly Payment Premium	1.10

We know that your trust in us is very important. We are committed to protecting your privacy rights. Please read this document carefully. It discloses your privacy rights.

Obtaining Information About You — We may obtain information from your application, a telephone interview with you, claims history with us, policies you have or had with us, account balances and premium payment history, and other sources, such as health care providers (medical information), and consumer reporting agencies (credit reports). Your address, birth-day, telephone number, social security number are examples of such information. An investigative consumer report may be prepared where information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted to obtain information as to your character, general reputation and personal characteristics. You may have to share such information with us, our affiliates, agencies or others working with us.

Our Use of Personal Information — We will share such information only with companies associated with us. We, or your agent or broker may use your information to offer you products or help you choose a product. We may, as permitted by the law and without your prior approval, give information about you to persons who do business for us, your agent or broker, other insurance companies, or other persons handling your business, insurance company support organizations, regulatory or law enforcement authorities; and our affiliated companies. Information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons.

YOUR RIGHTS

- The right to access, inspect and copy the personal information pertaining to you that we maintain in our files about you.
- The right to request that we correct or amend any personal information that we have about you.
- To request an interview in connection with the preparation of an investigative consumer report.

To exercise these rights, please send a written request to the attention of the Privacy Coordinator.

How We Protect Your Personal Information — We protect the information we share with companies working for us through an agreement. The agreement obligates those companies to keep your information confidential.

Only our employees who work to service your business see your personal information. We have trained our employees to closely follow our privacy rules for your protection. Your privacy rights will continue if you cease to be our customer.

THE REMAINDER OF THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required to maintain the privacy of your personal medical information and provide you with this notice as to our legal duties and privacy practices. We are required to abide by the terms of this notice. We reserve the right to change the terms of this notice and to make any new provisions effective to all of the medical information that we maintain about you. If we revise this notice, we will provide you with a revised notice by mailing the revised notice to the address you have supplied us.

STATEMENT OF YOUR RIGHTS

You have the right to know how we use or disclose your personal medical information. There are certain uses and disclosures of your personal medical information that we are permitted or required to make by law without your permission. In addition, you have:

- The right to request that we place additional restrictions on our uses and disclosures of your personal medical information, but we are not obligated to agree to any such restrictions.
- The right to access, inspect and copy the protected information pertaining to you that we maintain in our files, and the right to request that we correct or amend any personal medical information that we have about you.

- The right to receive an accounting of the disclosures of your personal medical information that we make for purposes other than activities related to your treatment, or our payment functions or other health care operations.
- The right to request that you receive communications of personal medical information in a confidential manner.
- The right to obtain a paper copy of this notice from us on request.

To exercise these rights please send a written request to the attention of the Privacy Coordinator.

PERMISSIBLE USES AND DISCLOSURES OF PROTECTED MEDICAL INFORMATION

Payment Functions. We may use or disclose your protected medical information without your permission to carry out activities relating to reimbursing you for the provision of health care, obtaining premiums, determining coverage, and providing benefits under the policy of insurance that you are purchasing. For example, payment functions may include (but are not limited to) reviewing health care services with respect to medical necessity, coverage under the policy, appropriateness of care, or justification of charges.

Health Care Operations. We may also use or disclose your protected medical information without your permission to carry out certain insurance-related activities. For example, these activities include using your protected information for underwriting, premium rating, or other activities relating to the creation, renewal or replacement of another contract of health insurance, placing a contract for reinsurance of risk relating to claims for health care, and performing audit functions to ensure compliance and proper claims payment.

Group Health Plan. We may disclose your protected medical information to your employer as necessary for the purpose of reporting claims experience or conducting an audit if you are covered under an employer-based group health insurance plan.

Business Associates. We may disclose your protected medical information to our business associates. There are some services provided in our company through contracts with our business associates.

Uses Permitted By Law. We may also use or disclose your protected medical information without your written permission for purposes permitted or required by law.

Authorized Uses. All other disclosures of your protected medical information will be made only with your written permission, and any permission that you give us may be revoked by you at any time.

COMPLAINTS ABOUT MISUSE OF INFORMATION — If you believe your privacy rights have been violated you may complain either directly to us or to the Secretary of Health and Human Services (H.H.S.). Please submit all complaints in writing and to us or H.H.S. as follows:

American Community Mutual Insurance Company
Attn: Privacy Officer
39201 Seven Mile Road
Livonia, MI 48152-1094

U.S. Department of Health and Human Services
Attn: Secretary
200 Independence Ave S.W.
Washington, DC 20201

You will not be retaliated against in any way for filing a complaint.

OBTAINING FURTHER INFORMATION — Please call us if you have any questions or comments. The phone number is (800) 991-2642.

Effective Date: April 14, 2003