

Authorized Benefit Plans, Inc.

Application Instructions For Time Insurance

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 Authorized Benefit Plans, Inc. for review along with the completed application. If you do not have access to a fax machine, send the completed application to Authorized Benefit Plans, Inc. 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 sign and date the authorization form.

Don't forget to **enclose a check for the required payment made payable to Time Insurance** if you are not paying by credit card for the first month.

Mail completed application and check to:

Authorized Benefit Plans, Inc.

Attn: New Enrollment

2131 E. Broadway #24

Tempe, AZ 85282

Authorized Benefit Plans, Inc. will review your application for completeness and accuracy before we submit it to Time Insurance for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at 480-502-6869 or e-mail us at service@authorizedbenefit.com.

Authorized Benefit Plans, Inc.

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:**

Authorized Benefit Plans, Inc.

FAX# 480-894-9707

Dear Authorized Benefit Plans, Inc.,

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

Name _____

E-mail _____

Date _____

Time _____

Please contact me at this phone number _____ after you have reviewed my application for completeness and accuracy.

I will contact Authorized Benefit Plans, Inc. at 480-502-6869 to verify receipt of my application.

****I understand that Authorized Benefit Plans, Inc. will not review this application until the following weekday morning if I faxed this application after 5:00PM or on a weekend**

I understand that the original signed application must still be mailed to Authorized Benefit Plans, Inc.. I will mail the original signed application to :

Authorized Benefit Plans, Inc.

Attn: New Enrollment

2131 E. Broadway #24

Tempe, AZ 85282

I will send the original application as soon as I have been contacted by Authorized Benefit Plans, Inc. with confirmation that my application has been received by fax and reviewed for completeness.

Signature: _____

Date: _____

**ENROLLMENT FORM FOR
MEDICAL INSURANCE FOR INDIVIDUALS AND FAMILIES**

PLEASE PRINT IN BLACK INK

AGENT INFORMATION

Agency Name and Time Number Authorized Benefit Plans, Inc.
 Agent Name and Time Number Phil Kiermayr 546480 00001 Phone # 480-502-6869
 Agent Fax Number 480-894-9707 General Agent is located in the state of _____

TYPE OF ACTIVITY check appropriate box

- New Enrollee** **Change to an existing policy. Policy #** _____
- Upgrading Coverage**
Existing Policy # _____
- Adding Dependent
 Reinstatement of Coverage
 Applying for removal of special exception rider
 Applying for removal/reduction of special class premium
 Other _____

PERSON(S) TO BE INSURED

Name		Sex	Age	Birthdate	State of Birth	Height	Weight	Social Security #	Tobacco User
Last	First			Mo/Day/Yr					Refer to p. 4, #28
1. (Primary)									<input type="checkbox"/> Yes <input type="checkbox"/> No
2. (Spouse)									<input type="checkbox"/> Yes <input type="checkbox"/> No

3. DEPENDENT'S NAME			Relationship	Sex	Age	Full Time Student		Birthdate	Height	Weight	Social Security #
Last	First	M.I.				Yes	No				

4. Resident Address

STREET CITY STATE ZIP

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

If yes, explain _____
(IN CASE OF A MINOR, CUSTODIAL PARENTS SIGNATURE WILL BE REQUIRED TO ATTEST TO MEDICAL HISTORY)

6. Home Phone Number: _____ AREA CODE NUMBER Best time to call _____

7a. Occupation (Primary): _____ Full-Time Part-time Hours worked per week _____

Company Name: _____ Work Phone Number: _____

Duties: _____

Self Employed: Yes No Covered by Worker's Compensation: Yes No

7b. Occupation (Spouse): _____ Full-Time Part-time Hours worked per week _____

Company Name: _____ Work Phone Number: _____

Duties: _____

Self Employed: Yes No Covered by Worker's Compensation: Yes No

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 or Child(ren) Life Insurance.)

POLICY INFORMATION - PLEASE PROVIDE A PROPOSAL/QUOTE

BILLING

9. Quarterly Semi-Annual Annual Bank Draft (Complete attached form) Existing Account # _____
 Send premium notices to: Insured Other (Print name, street number, city, state & zip)

OTHER COVERAGE IN FORCE OR APPLIED FOR

10. Are any of the proposed insureds covered by, or has application been made for any type of medical insurance?
 Yes (Complete section below) No

Proposed Insured's Name	Company Name	Company Phone Number	Group/Individual/COBRA	Type of Coverage	Effective Date	Termination Date

11. Were all proposed insureds covered under the prior plan listed above? Yes No (If no, list those not covered)
-
12. Will this proposed coverage replace or change any existing health insurance? Yes No
13. Are any of the proposed insureds covered by Medicaid? Yes No
14. Will any proposed insured become eligible for any other form of medical insurance in the next six months? Yes No
15. 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 & DRIVING

16. Have any of the proposed insureds ever 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?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

17. 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 _____

HEALTH STATEMENT

IMPORTANT! PLEASE GIVE COMPLETE DETAILS OF EACH YES ANSWER ON PAGE 5 "ADDITIONAL MEDICAL DETAILS".

WITHIN THE LAST 10 YEARS HAS ANY PROPOSED INSURED:

- | | Yes | No |
|---|--------------------------|--------------------------|
| 18. 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? (provide last blood pressure reading and cholesterol level if known) | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| g) The genitourinary system including but not limited to any kidney disorder, kidney stones, cystitis, prostatitis, bladder infections, or sexually transmitted disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| h) Diabetes, high or low blood sugar or any disorder of the thyroid gland or other glandular disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| j) Blood or lymph disorders including but not limited to anemia or lymphadenopathy? | <input type="checkbox"/> | <input type="checkbox"/> |
| k) Cancer? Provide location, type of cancer and treatment received | <input type="checkbox"/> | <input type="checkbox"/> |
| l) Tumor, cyst or growth of any kind; any breast or skin disorders? Provide location, state if treated or removed and date | <input type="checkbox"/> | <input type="checkbox"/> |
| m) Any disorder of the eyes, ears, (including ear infections or ear tubes), nose or throat. Tonsils or adenoids, any speech or hearing impairment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. To the best of your knowledge, are you, your spouse or any dependent now pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is any person not named on this enrollment form now pregnant by any person to be insured? | <input type="checkbox"/> | <input type="checkbox"/> |

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

QUESTIONS 4-6 FOR FEMALE APPLICANTS:

- | | | |
|--|--------------------------|--------------------------|
| 4. Complications of pregnancy, including but not limited to caesarean section delivery or miscarriage? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. DATE OF LAST PAP SMEAR _____ RESULTS _____ | | |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) by a member of the medical profession? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Been diagnosed as having or been treated for any immune deficiency disorder by a member of the medical profession? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Had surgery or has diagnostic testing, treatment or surgery been recommended or scheduled that has not been completed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. 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? If yes, give name of physician or hospital and results. | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Used sedatives, tranquilizers, cocaine or other hallucinogenic or narcotic drugs, or received treatment for drug abuse or chemical dependency? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. To the best of your knowledge, does any person to be insured have any mental or physical impairment, disease or deformity not indicated above? | <input type="checkbox"/> | <input type="checkbox"/> |

HEALTH STATEMENT (continued)

IMPORTANT! PLEASE GIVE COMPLETE DETAILS OF EACH YES ANSWER ON PAGE 5 "ADDITIONAL MEDICAL DETAILS".

- | | Yes | No |
|--|--------------------------|--------------------------|
| 28. Have you or your spouse (if to be insured) smoked cigarettes or used tobacco in any form or nicotine substitute within the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| | Primary Proposed Ins. | |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| | Spouse | |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 28a. Have you or your spouse EVER smoked cigarettes or used tobacco products? If yes, indicate who, amount per day and year quit. | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Is any proposed insured currently taking or taken within the past 3 months, any medication or receiving medical treatment of any kind? Provide details of treatment including name and dosage of all medications. | <input type="checkbox"/> | <input type="checkbox"/> |

REQUESTING THE REMOVAL OF A SPECIAL CLASS PREMIUM OR RIDER

30. Has there been any medical treatment for, or have you consulted with a physician concerning the condition(s) which has been ridered or rated since the covered person's effective date? Yes No If yes, provide details _____

REGULAR PHYSICIAN

31. Regular physician or medical practitioner for each proposed insured: (If none, provide last doctor seen, date, reason & results)

Primary Proposed Insured's Physician _____

Address _____

Date Last Seen _____ Reason & Results _____

Spouse'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 _____

Child's Name _____ Physician _____

Address _____

Date Last Seen _____ Reason & Results _____

ADDITIONAL MEDICAL DETAILS

(Attach a separate sheet if additional space is needed. Date and sign any additional sheet.)

	Provide dates, type of treatment, and results.	Name of Doctor or Hospital and Complete Address and Phone Number.
Person Question No.		
Condition:		
Person Question No.		
Condition:		
Person Question No.		
Condition:		
Person Question No.		
Condition:		
Person Question No.		
Condition:		
Person Question No.		
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Person Question No.		
Condition:		
Person Question No.		
Condition:		
Person Question No.		
Condition:		

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 Time Insurance Company, will be in force only when issued by Time Insurance Company. The first full premium must be paid. Coverage will become effective on the later of: A) The date of 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.

In order to determine my (our) eligibility for insurance, I authorize any licensed physician; medical practitioner; hospital; clinic; any medically related facility; insurance company; the Medical Information Bureau; employer; or consumer reporting agency to give to Time Insurance Company (or to any consumer reporting agency authorized by Time Insurance Company) any information regarding me or my family as to employment, other insurance coverage, personal information, and medical care, advice or treatment.

I agree that a photographic copy of this authorization shall be valid for two years from the date signed. You or your authorized representative are entitled to receive a copy of this authorization.

I acknowledge receiving the Fair Credit Reporting Act Pre-Notification, the notification regarding the Medical Information Bureau, 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.

A.M.

P.M.

Signature of Primary Proposed Insured

DATE SIGNED TIME SIGNED CITY & STATE

Signature of Spouse or Other Insured
(If proposed to be insured)

Signature(s) of Other Dependents 18 or Over
(If proposed to be insured)

Guardian's Signature

Requested Effective Date _____

Premium Amount Sent \$ _____

20.00

One Time Processing Fee Sent* \$ _____

*N/A in all states

Conditional Receipt Taken? Yes No

ATTENTION: (Agent)

I have reviewed this enrollment form to ensure that all required items have been completed.

To the best of my 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
Phil Kiermayr **546480 00001**

Print Agent Name & Agent Number or Business Number

_____ Initial here if you witnessed the signing of this form by the Proposed Insured(s).

Time Insurance Company Authorization for Check-O-Matic Billing

Choose the following option that applies:

- To begin Check-O-Matic withdrawals
- To add this policy to an existing Check-O-Matic account with Time Insurance Company.

Note: Please provide the existing Check-O-Matic number and/or associated policy number.

Existing COM Number _____

Associated Policy Number _____

Desired withdrawal day: (1-28) _____

Note: We recommend a withdrawal date equal to or within 5 days of your policy issue day.

ACCOUNT INFORMATION: Complete only if different than information on check:

PAYOR'S BILLING ADDRESS

Payor's Name _____

Address _____

City _____ State _____ ZIP _____

I (we) hereby authorize Time Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account indicated below and the depository named below, herein after called DEPOSITORY, to debit the same to such account.

This authority is to remain in full force and effect until COMPANY and DEPOSITORY has 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.

X _____ **X** _____
(Signature of Payor) (Date Signed)

PLEASE ATTACH VOIDED CHECK

Health Advocates Alliance Membership Application

USAA customers are not required to complete this section.

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 right 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 Name (please print) _____

Member Signature _____

Date _____

FAIR CREDIT

FAIR CREDIT REPORTING ACT AND PRIVACY ACT PRE-NOTIFICATION

Thank you for considering Time Insurance Company as your insurance carrier. Your enrollment form will be processed as quickly as possible. Public Law 91-508 and state privacy acts require that we advise you that an investigative consumer report may be made in connection with this enrollment form which will provide applicable information concerning character, general reputation, personal characteristics and mode of living. The information for this report may be obtained through telephone or personal interviews with you, your friends, neighbors and associates. You may request an interview in connection with the preparation of the report. Upon written request, you are entitled to receive a copy of the report.

NOTIFICATION REGARDING THE MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request form from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. Time Insurance Company or its reinsurers may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may also apply for life, disability or medical insurance, or to whom a claim for benefits may be submitted.

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

Information collected by us and used to issue an insurance policy or certificate may 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 Time Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin 53203.

FRAUD WARNING

Any person who, with intent to defraud or knowingly presents false information on an application for insurance, or files a false or fraudulent claim for payment of a loss or benefit, is guilty of insurance fraud. Any person found guilty of insurance fraud may be subject to fines and confinement in prison.

CONDITIONAL RECEIPT

Received from: _____, this _____ day of _____, _____.

The sum of \$_____ in connection with the enrollment form for Medical Insurance with Time Insurance Company.

No insurance will become effective prior to contract delivery. Except, insurance may become effective prior to the contract delivery if and when each and every condition contained in this receipt is met. No agent or broker of the Company is authorized to alter or waive any of the following conditions:

The conditions under which insurance may become effective prior to contract delivery are as follows:

1. The Proposed Insured(s) must be, on the Effective Date, as hereafter defined, a risk acceptable to the Company under its rules, standards and practices for the exact contract and premium applied for, without any modification.
2. The amount of the payment taken with the enrollment form must be equal to the amount of the full first premium payment selected.
3. The contract is issued exactly as applied for within 60 days from the date of the enrollment form. If the contract is not issued within 60 days from the date of enrollment, there will be no coverage provided under the terms of this Conditional Receipt. Any coverage provided by the Conditional Receipt ends when the contract is delivered.
4. Proposed Insured(s) agree to complete the medical information report as part of the enrollment process.

If each of the above conditions are fulfilled, then the insurance as provided by the terms and conditions of the contract applied for will become effective on the Effective Date prior to the contract delivery.

"Effective Date" as used herein means the later of: a) the date the enrollment form is signed; and b) the requested Effective Date.

If one or more of the conditions are not met, the liability of the Company will be limited to the return of the sum received.

AGENT'S SIGNATURE

PROPOSED INSURED'S SIGNATURE

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY — DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK