

# Application for American Community Mutual Individual Health Insurance *Indiana*



## PART I

### A. INSTRUCTIONS FOR APPLICANT

Thank you for applying to American Community Mutual Insurance Company. Your health insurance is important protection and the application process is a crucial part of securing coverage for you and your family. Please take the time to carefully complete this application; your answers will become part of the underwriting process and the insurance contract. When completing the application, please follow these procedures:

1. The Application is to be completed by the Key Applicant (Proposed Insured). Children only policies require the parent or guardian who has custody and care of the children to complete and sign the application.
2. Please print in black ink only. Signatures are to be written and must be legible (dependents age 16 and over must sign the application).
3. Corrections to answers can be made by drawing a straight line through the incorrect answer and printing the correct response above the lined-out answer. Applicant must then initial and date the correction.
4. Errors in signature(s) and/or date/time cannot be corrected. A new application is required.
5. Applications should be completed and mailed as soon as possible so they are received at the Home Office of American Community within 30 days of the application date.
6. **Do not cancel your existing insurance coverage** until your new American Community policy has been issued and the policy has been delivered and fully accepted by you.
7. Your new insurance at American Community will be in force when all of the following events take place:
  - a. The application has been approved for policy issue by the Home Office Underwriting Department.
  - b. Any amendments/exclusion riders to the policy have been signed by the Applicant and received at our Home Office.
  - c. The first full premium has been paid and received at American Community.The effective date of coverage will be the requested special date or the underwriting approval date or the date a rated or modified policy quote is accepted in writing by the Applicant.
8. Type of Application:  New Application    Rewrite of Existing American Community Plan    Trial Application  
 New Application for Children Only

**B. SCHEDULE OF PERSONS PROPOSED FOR INSURANCE**

List all Family Members. If children are to be insured, include all children, stepchildren and adopted children of the Applicant who are dependent on the Applicant and are at least 15 days old but have not reached their 22nd birthday. Please include maiden names of females in parentheses.

Full Name (First-Middle-Last)	Relationship to Applicant	Sex M F	Date of Birth	Place of Birth	Marital Status	Height Ft. In.	Weight Lbs.	Social Security Number
1. (Key Applicant)								
2. (Spouse)								
3. Names of Dependents								
4. Applicant Driver's License Number _____ State _____								
Spouse Driver's License Number _____ State _____								
Dependent's Driver's License Number _____ State _____								
5. Residence Address _____ Street _____ City _____ State _____ Zip Code _____ County _____								
6. If any proposed insured does not live at the above residence, please explain: _____								
7. Billing Address _____ Street _____ City _____ State _____ Zip Code _____ County _____ (if other than residence)								
8. Occupation of Applicant: _____ Employer: _____ <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Self-Employed Income _____ Duties _____								
9. Occupation of Spouse: _____ Employer: _____ <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Self-Employed Income _____ Duties _____								
10. Home Phone Number ( ) _____ Work Phone Number ( ) _____								

**C. PLAN OF HEALTH INSURANCE AND OPTIONAL BENEFITS APPLIED FOR**

**COVERAGE APPLIED FOR:** Mark appropriate deductible, co-insurance and optional benefit(s) for plan selected

Plan	Medalist	Community Med 100
<b>Co-Insurance</b>	<input type="checkbox"/> 80% of \$5,000/50% of \$10,000 <input type="checkbox"/> 80% of \$10,000/50% of \$20,000 <input type="checkbox"/> 70% of \$5,000/50% of \$10,000 <input type="checkbox"/> 70% of \$10,000/50% of \$20,000	<input type="checkbox"/> 100%/75% of 16,000
<b>CHOOSE Copay w/ Deductible OR Deductible Only</b>	<input type="checkbox"/> \$25, \$500/\$1,000 <input type="checkbox"/> \$30, \$1,000/\$2,000 <input type="checkbox"/> \$35, \$1,500/\$3,000 <input type="checkbox"/> \$40, \$2,500/\$5,000 <input type="checkbox"/> \$40, \$5,000/\$10,000	<input type="checkbox"/> \$1,500/\$3,000 <input type="checkbox"/> \$2,500/\$5,000 <input type="checkbox"/> \$3,500/\$7,000 <input type="checkbox"/> \$5,000/\$10,000
<b>Optional Benefits</b>	<input type="checkbox"/> Dental <input type="checkbox"/> Maternity <input type="checkbox"/> Preventive Care	<input type="checkbox"/> Dental <input type="checkbox"/> Maternity <input type="checkbox"/> \$500 Prescription Drug Deductible
<b>PPO NETWORK</b>	<input type="checkbox"/> PHCS <input type="checkbox"/> Sagamore Plus	

**D. PREMIUMS PAYABLE** Health and Life premiums are calculated at age last birthday, based on the effective date requested for this insurance.

\*\*Estimated Modal Premium as Quoted by Agent: \$ \_\_\_\_\_

**Initial Premium Payment Options:**

- Visa  MasterCard  Debit Card Card No. \_\_\_\_\_ Exp. Date \_\_\_\_\_  
I authorize American Community to charge the full initial premium payment to my Visa/MasterCard/Debit Card.
- Electronic Funds Transfer (EFT) from Checking Account** (COMPLETED EFT AUTHORIZATION FORM REQUIRED)  
I acknowledge that American Community will notify me of the exact amount and approximate date of the initial checking account withdrawal prior to the withdrawal date. This option is only available if regular monthly premium payments are also to be withdrawn from the same checking account.
- Check** Amount Enclosed \$ \_\_\_\_\_ (minimum one month's premium; two months' minimum premium recommended with application if effective date requested is within 30 days of application date).  
In the event of a balance being due upon approval of this application, I authorize American Community to:
  - Charge my  Visa  MasterCard  Debit Card for the balance due. Card No. \_\_\_\_\_ Exp. Date \_\_\_\_\_
  - Withdraw the amount due from my checking account (COMPLETED EFT AUTHORIZATION FORM REQUIRED). I acknowledge that American Community will notify me of the exact amount and approximate date of the initial checking account withdrawal prior to the withdrawal date. This option is only available if regular monthly premium payments are also to be withdrawn from the same checking account.
  - Bill me

**Billing Options:**

- Annually  Semi-Annually  Quarterly  Monthly\*  EFT  New List Bill\* (List Bill Agreement required)  List Bill No. \_\_\_\_\_

\*Administrative Charge: Once approved, an additional Billing Fee of \$4.75 will be applied for Monthly Billing (fee is waived for EFT, Quarterly, Semi-Annually or Annually). A \$10 per month Billing Fee will be charged for List Bill.

\*\*I understand that the estimated premium is only an estimate and that the actual premium billed may be different depending on the information I provided in this application, additional information obtained during medical underwriting or the time of underwriting approval.

**E. PLAN OF LIFE INSURANCE AND OPTIONAL BENEFITS APPLIED FOR - Maximum \$95,000 face amount total insurance at American Community Mutual and maximum age 60**

**TERM POLICY PLAN**     10 Year     15 Year     20 Year

Face Amount \$ \_\_\_\_\_

Spouse Rider - Amount \$ \_\_\_\_\_

Child Rider - Amount \$ \_\_\_\_\_

Waiver of Premium (Life only)

Accidental Death - Amount \$ \_\_\_\_\_

Proposed Insured:     Std. (Tobacco User)     Non-Tobacco User

Spouse:     Std. (Tobacco User)     Non-Tobacco User    Age \_\_\_\_\_

Applicant's Beneficiary:

Primary \_\_\_\_\_ Relation \_\_\_\_\_

Contingent \_\_\_\_\_ Relation \_\_\_\_\_

Spouse's Beneficiary (if spouse rider):

Primary \_\_\_\_\_ Relation \_\_\_\_\_

Contingent \_\_\_\_\_ Relation \_\_\_\_\_

Owner will be the insured unless otherwise stated here \_\_\_\_\_

**F. EXISTING COVERAGE AND REPLACEMENT**

1. Are any of the Applicants covered by other Health or Life insurance now or has an application been made by any of the Applicants for any type of medical insurance?     Yes — Complete section below     No

Applicant(s) Name(s) (First-MI-Last)	Company Name	Group or Individual	Policy Number	Type of Insurance	Effective Date	Termination Date

2. Will the proposed American Community coverage replace or change any existing health or life insurance?     Yes     No

3. If group Health insurance is being replaced, please document the following information (required for Indiana residents):

Group Certificate Number: _____	<b>Coverage</b>	<b>Start Date</b>	<b>End Date</b>
Insurance Company: _____	Medical	_____	_____
Key Insured's Name: _____	Prescription Drug	_____	_____
Participant's Name(s): _____	Dental	_____	_____
_____	Vision	_____	_____
_____			

4. Have any of the Applicants ever been declined, postponed, rated or charged an extra premium or had a portion of coverage excluded for medical, life or disability insurance?     Yes — Give details below     No

**G. QUESTIONS APPLY TO EACH APPLICANT PROPOSED FOR INSURANCE:**

- |  | Yes                      | No                       |  | Yes                      | No                       |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Have you or any family member to be insured, in the last 10 years, smoked cigarettes, cigars, pipes or used any form of tobacco such as chewing? If yes, complete the following:<br>Name: _____<br>Form of tobacco used: _____<br>No. of yrs. used: _____ Date of last use (if quit): _____   | <input type="checkbox"/> | <input type="checkbox"/> | *7. During the past 8 years, have you been advised to limit your use of alcohol, been told to seek treatment for or been treated for alcohol or drug usage, or been a member of AA or other similar group?<br>If yes, please give details and applicant(s) name(s) _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you lived outside the United States within the past 12 months?<br>If yes, who? _____<br>Where _____ Date of Re-entry _____   | <input type="checkbox"/> | <input type="checkbox"/> | *8. Have you, in the past 8 years, used cannabis, barbiturates, narcotics, hallucinogenic drugs or other controlled substances? If yes, please give details and applicant(s) names _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you plan to travel outside the United States in the next 12 months?<br>If yes, who? _____<br>Where? _____ How long? _____  | <input type="checkbox"/> | <input type="checkbox"/> | *9. Have you, in the past 8 years, had an alcohol or drug related arrest?<br>If yes, please give date(s) and applicant(s) name(s) _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you engage in scuba or sky diving, organized racing, flying or other hazardous activities?<br>If yes, who? _____<br>What activity? _____<br><b>(If yes, submit Aviation/Avocation Questionnaire.)</b>  | <input type="checkbox"/> | <input type="checkbox"/> | * <b>If questions 7, 8 or 9 are answered yes, please submit an alcohol and drug questionnaire for each Applicant named.</b>  |                          |                          |
| 5. Are you, your spouse, significant other person, or any dependent or adopted child (whether or not listed on this application) now pregnant?<br>If yes, <b>Do Not Submit Application.</b>  | <input type="checkbox"/> | <input type="checkbox"/> | 10. Have you had your driving license suspended or revoked for any reason in the past 10 years?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you now or have you in the past 10 years, used alcoholic beverages?<br>If yes, who? _____<br>If yes, for how long? _____<br>Average more than three drinks daily? <input type="checkbox"/> <input type="checkbox"/><br>Average more than 25 drinks weekly? <input type="checkbox"/> <input type="checkbox"/><br>(One drink equals one 12 oz. Beer or one 4 oz. Wine or one 2 oz. Cocktail) | <input type="checkbox"/> | <input type="checkbox"/> | 11. I believe that I qualify for guaranteed coverage under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).<br>If yes answer: Attach completed HIPAA Certificate of American Community Mutual Insurance Company and copy of group certificate(s) documenting at least 18 months of creditable prior insurance coverage with no breaks in coverage exceeding 62 days. | <input type="checkbox"/> | <input type="checkbox"/> |

**PART II  
MEDICAL HISTORY**

Questions apply to each Applicant proposed for insurance. Give complete details of "Yes" answers, including date, details, diagnosis, treatment and name and address of doctor or medical facility (attach separate sheet if necessary). American Community underwriters **will not** routinely request medical records on you or your family members.

**Benefits will be paid for a sickness, injury or condition that existed prior to the time insurance is effective only if such sickness, injury or condition is fully and completely disclosed on this application and not excluded from coverage by a rider or policy exclusion.**

**A. Within the past 5 years has any Applicant had any diagnosis of, received treatment for, or consulted with a physician concerning (Please document details of Yes answers in Section B below):**

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. 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"/> |
| 2. 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?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. The digestive system including but not limited to ulcer, gastritis, intestinal disorder, colitis, gall bladder, hemorrhoids, hernia, disorder of the pancreas, spleen, or liver including but not limited to, hepatitis, jaundice or cirrhosis?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. The nervous system including but not limited to epilepsy, convulsions, headaches, paralysis, Parkinson's disease, stroke or vertigo?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. 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"/> |
| 6. The genito-urinary 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"/> |
| 7. Diabetes, high or low blood sugar or any disorder of the thyroid gland or other glandular disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. The muscular or skeletal system including but not limited to arthritis, gout, rheumatism, 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"/> |
| 9. Blood or lymph disorders including but not limited to anemia or lymphadenopathy (swollen lymph nodes)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Cancer? Provide location, type of cancer and treatment received _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. 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"/> |
| 12. Any disorders 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"/> |
| 13. 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"/> |
| 14a. Have you ever tested HIV positive by the Elisa, Western Blot blood testing procedure?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14b. Been diagnosed as having or been treated for Human Immunodeficiency Virus (HIV) by a member of the medical profession?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Been diagnosed as having or been treated for any immune deficiency disorder by a member of the medical profession? 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"/> |
| 16a. Had surgery or had diagnostic testing, treatment or surgery been recommended or scheduled that has not been completed?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 16b. Have you any symptoms or condition for which you intend to seek medical advice or treatment?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. 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"/> |
| 18. Had an electrocardiogram, chest x-ray, or blood study or any other diagnostic testing of any kind or been hospital confined in the past 10 years? If yes, give name of applicant and name of physician or hospital and results _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Is any Applicant currently taking or taken within the past 3 months, any medication or receiving medical treatment of any kind? Provide details of treatment for each applicant including name and dosage of all medications _____   | <input type="checkbox"/> | <input type="checkbox"/> |

**QUESTIONS 20a.-20c. ARE FOR FEMALE APPLICANTS:**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 20a. Complications of pregnancy, including but not limited to caesarean section delivery or miscarriage?                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 20b. Date of last PAP Smear Results _____  |                          |                          |
| 20c. 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"/> |

**B. Please document details of all "Yes" answers to questions in Sections A above (additional space on last page).**

Question	Person	Dates	Treatment	Effects	Physician and Address

Key Applicant or Agent: You may use this space for additional information

**C. Regular physician or medical practitioner for each Proposed Insured:** (If none, provide last doctor seen, date, reason and results)

Key Applicant's Physician \_\_\_\_\_ Address \_\_\_\_\_  
Spouse's Physician \_\_\_\_\_ Address \_\_\_\_\_  
Child's Name \_\_\_\_\_ Physician and Address \_\_\_\_\_  
Child's Name \_\_\_\_\_ Physician and Address \_\_\_\_\_  
Child's Name \_\_\_\_\_ Physician and Address \_\_\_\_\_

**D. DECLARATIONS**

I have personally completed this application and I represent that the statements and answers are true and complete to the best of my knowledge and belief, and I understand that this application (Part I, Part II, and any other required parts) shall not be binding until approved by the Company at its Home Office. The undersigned Applicants and agent certify that each person proposed for insurance has read the complete application and that he/she realizes that any false statement or misrepresentation, if material to the risk, may result in loss of coverage under this policy. I acknowledge receipt of the Notification of Investigation, the Medical Information Bureau Notice, the Notice of Insurance Information Practices and the Summary of Your Rights notice.

It is agreed that no agent is authorized to make any contract for American Community Mutual Insurance Company or to determine insurability or to waive or alter any conditions of the application, the policy or the receipt, and that notice to or knowledge of the agent as to any facts, whenever given, shall not be deemed notice to the Company unless recorded in this application, and that the Company shall not be bound by any act or statement of the agent not contained in the application. I understand that I or any person proposed for insurance may request to be interviewed in connection with the preparation of an investigative consumer report. I acknowledge that disclosure of the name and address of my regular or attending physician does not constitute full disclosure (as required under this application) of the date, details, diagnosis, treatment, or remaining effects of any of my medical conditions. I certify that I am applying for personal insurance which is not part of any employer sponsored plan, no part of the premium will be paid by my employer and all persons to be insured are residents of Indiana. I understand and agree that if any action by me, my employer or any government or regulatory agency cause the policy applied for to be deemed group insurance, the policy will end on date of such action.

**NOTICE:** 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.

**Authorization To Obtain Information**

I authorize any physician, hospital, clinic or other medical or medically related facility, insurance company, Medical Information Bureau, or other insurance support organization, or consumer reporting agency that has any record or knowledge of the health, or public record information or information as to the character, general reputation, personal characteristics and mode of living, of any persons proposed for insurance to give to American Community Mutual Insurance Company, its legal representative or its reinsurers, any such record or knowledge for purposes of underwriting insurance. This authorization includes information about drug and alcohol use and psychiatric conditions. A photographic copy of this authorization shall be as valid as the original for 30 months from the date below. I know that I, or my authorized representative, may request and am entitled to receive a copy of this authorization.

**Arbitration**

Any dispute between the Policyholder or an Insured Individual and American arising out of or relating to this policy, or the alleged breach thereof, may be resolved by arbitration. The Policyholder or an Insured Individual must first utilize the grievance procedure at each appropriate level and exhaust the rights granted to them therein before resorting to arbitration. The arbitration may be binding on both parties or non-binding upon the insured, but in all instances must be entered into on a voluntary basis. By voluntarily agreeing to enter into an arbitration proceeding, the Policyholder or Insured Individual should be aware and understand that they may be giving up certain rights to have their dispute settled in and by a court of law, except to the extent that applicable state law may provide for judicial review of arbitration proceedings.

Please Initial \_\_\_\_\_

**Effective Date Requested**

- 1. Applicant requests a special effective date of \_\_\_\_\_, 20\_\_\_\_
  - a. The latest future effective date permitted is 90 days from the application date.
  - b. No effective date prior to application date is permitted.
- 2. If no special effective date is requested, the following will apply:
  - a. The effective date will be the underwriting approval date, or
  - b. If a rated premium or modified policy is quoted, the effective date will be the date the quote is accepted in writing by the applicant.
- 3. If replacing American Community Individual Coverage now in force, the future effective date must be the paid-to-date of policy being replaced.
- 4. If replacing coverage now in force, it is recommended to request a future effective date of at least 30 days from the application date.

**Agent's Certification**

Each question has been asked by me of the Applicant(s). All answers have been accurately recorded. I am not aware of any mental or physical impairment or deformity of any Applicant which is not disclosed on the application.  I did witness the signing of this application by the Applicant(s).  I did not witness the signing of this application by the Applicant(s) but I fully explained the questions on the application to the Key Applicant over the telephone. To the best of my knowledge and belief replacement of health or life insurance or annuity  is  is not involved.

\_\_\_\_\_  
Signature of Licensed Agent

\_\_\_\_\_  
Agent's Name — Please Print

\_\_\_\_\_  
Agent No.

\_\_\_\_\_  
Agent's Business Phone

\_\_\_\_\_  
Agent's Fax No.

\_\_\_\_\_  
Signature of Key Applicant/Owner

\_\_\_\_\_  
City and State                      Time                      Date Signed

\_\_\_\_\_  
Signature of Spouse (if proposed for insurance)

\_\_\_\_\_  
Signature of Dependent (age 16 and over)

\_\_\_\_\_  
Signature of Dependent (age 16 and over)

\_\_\_\_\_  
Signatures Required Above

**THIS APPLICATION MUST BE RECEIVED IN THE HOME OFFICE  
WITHIN 30 DAYS OF THE DATE SIGNED.**

**THIS APPLICATION IS VOID IF NOT APPROVED WITHIN 90 DAYS  
OF THE DATE SIGNED.**

**American Community Mutual Insurance Company  
Authorization Information For Electronic Funds Transfer For Premium Payment**

Electronic Funds Transfer is the automatic, monthly transfer of funds from your checking account to American Community Mutual Insurance Company for the express purpose of premium payment. The only participation requirement is that you maintain a regular checking account.

Name \_\_\_\_\_ Financial Institution \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_ Address \_\_\_\_\_

**(Attach a blank check marked "void." A deposit slip is not acceptable.)**

Telephone \_\_\_\_\_

Account and Authorization Signature(s) \_\_\_\_\_ Account Number \_\_\_\_\_

**Authorization Agreement For Electronic Funds Transfer For Premium Payment**

I authorize American Community Mutual Insurance Company of Livonia, Michigan to start an automatic periodic withdrawal against my checking account at the financial institution I have indicated. I also authorize the financial institution to charge these withdrawals to my checking account each month. The withdrawals are to pay premium for the policy for which I have applied. If the application for that policy is pending, there will be no withdrawal until the first premium due after my policy has been issued. I understand that the withdrawal will be automatically made each month and will appear on my statement. I also understand that my policy may lapse if my checking account does not have sufficient funds at the time of withdrawal.

I want this withdrawal to automatically continue until I write American Community telling them to stop. I agree to allow them reasonable time to do so (usually 14 days).

Signature of Key Applicant/Owner \_\_\_\_\_

Date Signed \_\_\_\_\_

**Attach Voided Check Here  
No Deposit Slips, Please**

**Returned Check Fee:** If any premium payment made directly by check or by EFT (electronic funds transfer), is returned for nonsufficient funds, a \$20 nonrefundable service fee will be applied. This fee will be due with your next premium payment.

**Complete if Life Insurance Requested (complete for all amounts applied for)**

**AGENT'S REPORT**

**To AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY, Livonia, Michigan**

PROPOSED INSURED'S NAME \_\_\_\_\_

1. This application was:  Solicited by the Agent  Proposed Insured Inquiry

2. How long have you known the Proposed Insured? \_\_\_\_\_

3. Are you related to Proposed Insured by blood or marriage?  Yes  No If yes, please explain \_\_\_\_\_

4. Did you see all persons proposed for insurance?  Yes  No

If no, please explain \_\_\_\_\_

5. What is the purpose of this insurance? \_\_\_\_\_

If Business Insurance, complete appropriate section of Agent's Report.

6. Proposed Insured's estimated gross annual income \_\_\_\_\_ Net Worth \_\_\_\_\_

7. Spouse's estimated gross annual income \_\_\_\_\_

8. Premium will be paid by:  Insured  Employer  Spouse  Parent  Other \_\_\_\_\_

9. If Proposed Insured is a minor:

a) Amount of insurance on father \_\_\_\_\_ b) Amount of insurance on mother \_\_\_\_\_

c) Amount of insurance on all brothers and sisters under age 18 \_\_\_\_\_

10. What is the insurable financial interest of the Beneficiary? \_\_\_\_\_

11. Are you aware of anything unfavorable about the health, character, habits, occupation, or family history of the Proposed Insured(s)?  Yes  No

If yes, give details \_\_\_\_\_

I hereby certify:

I have submitted replacement papers to American Community, if appropriate.

**I submit this application, assuming full responsibility for delivery of any policy issued and for payment of the first premium to the Company. I know of no condition affecting the insurability of the proposed risk not fully recorded within.**

Date \_\_\_\_\_ Agent's Name-Please Print \_\_\_\_\_

Agent's Number \_\_\_\_\_ Signature of Licensed Agent \_\_\_\_\_

**CONDITIONAL RECEIPT  
CONDITIONAL RECEIPT IF INITIAL PREMIUM ACCOMPANIES APPLICATION**

NO COVERAGE WILL BECOME EFFECTIVE PRIOR TO POLICY DELIVERY UNLESS AND UNTIL ALL CONDITIONS OF THIS RECEIPT ARE MET. NO AGENT HAS THE AUTHORITY TO ALTER THE TERMS OR CONDITIONS OF THIS RECEIPT.

Amount Received \$ \_\_\_\_\_ From \_\_\_\_\_ Date of Receipt \_\_\_\_\_  
in connection with an application for Health insurance bearing the same number as this receipt.

If (1) an amount equal to the first full premium is submitted; (2) all underwriting requirements, including any medical examination required by the Company's rules, are completed; (3) the Applicant(s) is on the effective date indicated above a risk acceptable for insurance exactly as applied for without modification of plan, premium rate, or amount under the Company's rules and practices, then insurance under the policy applied for shall become effective on the later of (a) the date of application, (b) the date of completion of all underwriting requirements, and (c) any effective date of issue requested in the application.

If any of the above conditions are not met, the liability of the Company shall be limited to the return of the amount submitted.

\_\_\_\_\_  
Agent's Signature

\_\_\_\_\_  
Agent's Name (Please Print)

\_\_\_\_\_  
Key Applicant's Name (Please Print)

THE COMPANY SHALL HAVE 90 DAYS FROM THE DATE OF APPLICATION TO CONSIDER AND ACT UPON APPLICATION. NOTICE OF THE DECISION WILL BE SENT TO THE KEY APPLICANT WITHIN 90 DAYS.

**IMPORTANT: Agents — This Disclosure Notice must be given to the Key Applicant in all cases. Key Applicant — Please retain for your records.**

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

I do not request immediate Conditional Receipt coverage \_\_\_\_\_

\_\_\_\_\_  
Key Applicant

\_\_\_\_\_  
Date

**THESE NOTIFICATIONS MUST BE DETACHED AND DELIVERED TO THE KEY APPLICANT**

**NOTIFICATION OF INVESTIGATION**

In connection with your application for insurance an investigation may be made whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry may include information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request to American Community Mutual Insurance Company within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation.

**NOTICE:** 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.

**Medical Information Bureau Notice**

Information regarding your insurability will be treated as confidential. American Community Mutual 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. American Community Mutual Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of 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.

**NOTICE OF INSURANCE INFORMATION PRACTICES**

To issue an insurance policy we need to obtain information about you and any other persons proposed for insurance. Some of that information may come from you and some may come from other sources. As part of our normal procedure for processing your application, 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. This inquiry, if obtained, typically includes information as to your character, general reputation and personal characteristics. You and other individuals proposed for insurance have the right to request an interview in connection with the preparation of an investigative consumer report. Information obtained from an investigative consumer report prepared by an insurance support organization may in certain circumstances be disclosed to third parties without authorization. You have a right to access and correction with respect to information collected about you; that is, you may obtain and inspect a copy of any report that is actually prepared. Address your request to receive additional information or a description of your rights to our Underwriting Department.



**THESE NOTIFICATIONS MUST BE DETACHED AND DELIVERED TO THE KEY APPLICANT**

**A SUMMARY OF YOUR RIGHTS**

The following is a description of the American Community Mutual Insurance Company procedures which allow you to review information about you in our files. We want you to understand how we protect the information we have about you and how you can help its accuracy. This is being provided to you in accordance with the requirement of the Insurance Information and Privacy Protection law in effect in your state of residence.

**YOUR RIGHT OF ACCESS TO INFORMATION IN OUR FILES**

You have certain rights concerning access to recorded personal information that we have collected and maintained in our policy files. In order to maintain the security of that information, access will be permitted only after proper identification has been submitted to us.

If you would like to have access to information about you, you must send a written request to American Community Mutual Insurance Company at the address shown below, indicating full name, address, telephone number and policy or certificate number. Within thirty (30) business days after receiving your request, we will contact you and tell you the nature and substance of the recorded personal information in our files. If you wish, we will mail copies of our records to you, or you may visit the American Community Mutual Insurance Company facility where your files are located, where you will be permitted to see and copy the records in person.

Also, we will tell you to whom we have disclosed items of recorded personal information within the last two (2) years, or to whom such information would normally have been disclosed.

This right does not extend to information which relates to and is collected in connection with or in reasonable anticipation of a claim or civil or criminal proceeding. In all cases, we reserve the right to disclose medical information through a medical professional designated by you.

**DISPUTED INFORMATION**

You may request correction, amendment or deletion of any information in our files pertaining to you. We will respond within thirty (30) business days. We will tell you if, in fact, we complied with your request.

If we agree that certain items should be corrected, amended or deleted, we will send notification of the change to any person to whom we may have disclosed the original information during the preceding two years, and will also notify any insurance support organizations to whom we have disclosed the information or who may have furnished the original information.

If we do not agree with you, we will notify any insurance support organization that furnished us the information, and any person you designate who may have received such information within the preceding two years, of the dispute regarding the information. Your statement of dispute will be sent to these parties if we did not comply with your request.

We at American Community Mutual Insurance Company hope that you find this description of our information practices helpful. We take our responsibilities and your rights very seriously. If you have any further questions about the items just discussed, or you wish to exercise any right available to you, please write to us at: American Community Mutual Insurance Company, 39201 Seven Mile Road, Livonia, Michigan, 48152, Attn: Medical Underwriting Department.

**REASONS FOR ADVERSE UNDERWRITING DECISIONS**

In the event of an adverse underwriting decision, American Community Mutual Insurance Company shall:

- (1) Either provide the Applicant, policyholder or individual proposed for coverage with the specific reason(s) for the adverse underwriting decision in writing or advise such person that, upon written request, he or she may receive the specific reason(s) in writing.
- (2) Upon receipt of a written request within ninety (90) business days from the date of mailing of notice or other communication of an adverse underwriting decision to an Applicant, policyholder or individual proposed for coverage, American Community Mutual Insurance Company shall furnish to such person within twenty-one (21) business days from the date of receipt of such written request:
  - (a) The specific reason(s) for the adverse underwriting decision, in writing, if such information was not initially furnished in writing.
  - (b) The specific items of personal and privileged information that support those reasons for the adverse underwriting decision. However: American Community Mutual Insurance Company shall not be required to furnish specific items of privileged information if it has reasonable suspicion that the Applicant, policyholder or individual proposed for coverage has engaged in criminal activity, fraud, material misrepresentation or material non-disclosure. Specific items of medical record information will be disclosed to a licensed medical professional designated by you.