

Member Application to Taxpayers Network Inc.

New Member/Existing Member(Name of Member Paying Dues)

Name: _____ Social Security Number: _____

Business Name (if applicable): _____

Address: _____ City: _____

State: _____ ZIP: _____ Home Phone Number: () _____

Work Phone Number: () _____ Fax Number: () _____

If existing member, dues paid through: _____/ _____/ _____

Please enroll me as a member of Taxpayers Network Inc. If you are not an existing member, the information provided completes your TNI enrollment.

Signature Required X _____



Taxpayers Network Inc. is a membership association recognized by the IRS as a 501(c)(4) nonprofit organization. Membership dues, contributions or gifts to Taxpayers Network Inc. are not deductible as charitable contributions for federal income tax purposes. Membership dues for Taxpayers Network Inc. are \$7 per month (\$84 per year). Members receive the educational newsletter *Taxpayers Network Quarterly* including coupons redeemable for booklets and paperbacks on selected important public issues. Members also receive a valuable package of benefits, discounts and options. Membership dues are subject to change without notice.

Taxpayers Network, Inc. (TNI) agrees to indemnify and defend United Wisconsin Life Insurance Company (UWLIC) Agents/Agencies, their directors, officers, and employees from any and all claims, actions, damages, and other proceedings, together with all costs, including reasonable attorney's fees, arising out of any act, error, or omission by TNI occurring in connection with membership benefits and services, as described in writing in the Member's benefit guide.

Depending upon state law, this information may be submitted as evidence of insurability.

MEDICAL HISTORY

A. Yes No Have you or any eligible dependent ever been declined, postponed, rideder, or rated up for medical, disability, or life insurance with another insurance carrier? If yes, explain _____

B. Yes No In the past 24 months, have you or any person to be insured received treatment, received therapy, taken medication, or consulted a health care provider for symptoms? If yes, explain _____

C. Yes No In the past 24 months, have you or any person to be insured been advised to have a test or treatment, been advised to obtain equipment or service or been advised of a condition that may require attention or treatment? If yes, explain: _____

D. Yes No Has any person to be insured ever been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex by a physician or member of the medical profession, or tested positive for HIV? If yes, list names: _____

E. Yes No Has anyone to be insured used tobacco products during the previous 12 months? If yes, list names: _____

F. Within the past five years, has any person to be insured ever had any symptoms, conditions, diagnosis, consultation, treatment, therapy, been prescribed any medication, been monitored, or received counseling for any of following?... (Provide details to "Yes" answers below.)

1. Abnormal Test Results..... <input type="checkbox"/> Yes <input type="checkbox"/> No	22. Epilepsy/Seizure..... <input type="checkbox"/> Yes <input type="checkbox"/> No	42. Pap Smear, abnormal..... <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Alcoholism/Alcohol Abuse..... <input type="checkbox"/> Yes <input type="checkbox"/> No	23. Eye..... <input type="checkbox"/> Yes <input type="checkbox"/> No	43. Paralysis..... <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Allergies..... <input type="checkbox"/> Yes <input type="checkbox"/> No	24. Fracture/Dislocation/Internal Fixation..... <input type="checkbox"/> Yes <input type="checkbox"/> No	44. Prostate..... <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Arthritis/Pain Disorder..... <input type="checkbox"/> Yes <input type="checkbox"/> No	25. Gallbladder..... <input type="checkbox"/> Yes <input type="checkbox"/> No	45. Rectum Colitis; Irritable Bowel; Other Intestinal Disorder..... <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Asthma/Respiratory/Sleep Apnea..... <input type="checkbox"/> Yes <input type="checkbox"/> No	26. Headaches/Migraines..... <input type="checkbox"/> Yes <input type="checkbox"/> No	46. Reproductive Organs..... <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Back/Muscle/Joints..... <input type="checkbox"/> Yes <input type="checkbox"/> No	27. Heart/Murmur..... <input type="checkbox"/> Yes <input type="checkbox"/> No	47. Sexually Transmitted Diseases..... <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Bladder..... <input type="checkbox"/> Yes <input type="checkbox"/> No	28. Heart Valve/Mitral Valve Prolapse..... <input type="checkbox"/> Yes <input type="checkbox"/> No	48. Sinus..... <input type="checkbox"/> Yes <input type="checkbox"/> No
8. Blood Abnormality..... <input type="checkbox"/> Yes <input type="checkbox"/> No	29. Hepatitis/Liver..... <input type="checkbox"/> Yes <input type="checkbox"/> No	49. Skin/Growth/Lesion/Abnormality..... <input type="checkbox"/> Yes <input type="checkbox"/> No
9. Bone Disease/Deformity..... <input type="checkbox"/> Yes <input type="checkbox"/> No	30. Hernia..... <input type="checkbox"/> Yes <input type="checkbox"/> No	50. Spinal Disorder..... <input type="checkbox"/> Yes <input type="checkbox"/> No
10. Breast/Implants/Fibrocystic Breast..... <input type="checkbox"/> Yes <input type="checkbox"/> No	31. High Blood Pressure/Hypertension..... <input type="checkbox"/> Yes <input type="checkbox"/> No	51. Stroke..... <input type="checkbox"/> Yes <input type="checkbox"/> No
11. Cancer/Leukemia/Hodgkin's/Lymphoma..... <input type="checkbox"/> Yes <input type="checkbox"/> No	32. Infertility Testing/Treatment..... <input type="checkbox"/> Yes <input type="checkbox"/> No	52. Thyroid or Goiter..... <input type="checkbox"/> Yes <input type="checkbox"/> No
12. Colitis/Spastic Colon/Polyps..... <input type="checkbox"/> Yes <input type="checkbox"/> No	33. Kidney..... <input type="checkbox"/> Yes <input type="checkbox"/> No	53. Transplants..... <input type="checkbox"/> Yes <input type="checkbox"/> No
13. Congenital Abnormality..... <input type="checkbox"/> Yes <input type="checkbox"/> No	34. Lupus/Systemic or Discoid..... <input type="checkbox"/> Yes <input type="checkbox"/> No	54. Tuberculosis..... <input type="checkbox"/> Yes <input type="checkbox"/> No
14. Cystic Fibrosis..... <input type="checkbox"/> Yes <input type="checkbox"/> No	35. Lymphadenopathy/Immune System..... <input type="checkbox"/> Yes <input type="checkbox"/> No	55. Tumors/Growths/Cysts/Fibroids/Lesions..... <input type="checkbox"/> Yes <input type="checkbox"/> No
15. Diabetes/Pancreas..... <input type="checkbox"/> Yes <input type="checkbox"/> No	36. Menstrual Disorder..... <input type="checkbox"/> Yes <input type="checkbox"/> No	56. Ulcerative Colitis, Crohn's or Regional Ileitis..... <input type="checkbox"/> Yes <input type="checkbox"/> No
16. Digestive System..... <input type="checkbox"/> Yes <input type="checkbox"/> No	37. Mental, Nervous, Psychological..... <input type="checkbox"/> Yes <input type="checkbox"/> No	57. Ulcers-Digestive, Skin, Other..... <input type="checkbox"/> Yes <input type="checkbox"/> No
17. Drug or Substance Addiction/Abuse..... <input type="checkbox"/> Yes <input type="checkbox"/> No	38. Mental Retardation/Down's Syndrome..... <input type="checkbox"/> Yes <input type="checkbox"/> No	58. Urinary Tract..... <input type="checkbox"/> Yes <input type="checkbox"/> No
18. Ear/Throat..... <input type="checkbox"/> Yes <input type="checkbox"/> No	39. Multiple Sclerosis..... <input type="checkbox"/> Yes <input type="checkbox"/> No	59. Vascular Abnormality..... <input type="checkbox"/> Yes <input type="checkbox"/> No
19. Eating Disorder-Anorexia, Bulimia, Other..... <input type="checkbox"/> Yes <input type="checkbox"/> No	40. Muscular Dystrophy/Cerebral Palsy..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
20. Emphysema/Lung/COPD..... <input type="checkbox"/> Yes <input type="checkbox"/> No	41. Neurological Disease/ Disorder/Impairment..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
21. Endocrine System..... <input type="checkbox"/> Yes <input type="checkbox"/> No		

Provide details to "YES" answers (If more space is needed, attach an additional sheet of paper, sign and date it.)

Question Letter/No.	Name	Illness/Impairment	Dates Treated	Medications/Treatment/Surgery/Physician's Name & Address

Prior Coverage

Prior Coverage Information for HIPAA Guaranteed Issue Plans

Do you meet the requirements of a Federally Eligible Individual under HIPAA legislation (P.L. 104-191)? Please indicate yes or no or N/A to the following:

Yes No N/A 1. Have you or your dependents had a total of 18 or more consecutive months of prior health coverage, the most recent being an employer sponsored plan?

Yes No N/A 2. Are you or your dependents ineligible for coverage under a group plan, Medicare Part A or B, or Medicaid, and do not have any health coverage now in force?

Yes No N/A 3. Was your or your dependents most recent employer sponsored health insurance plan coverage terminated for any of the following reasons: fraud, nonpayment of premiums on your behalf, or intentional misrepresentation of material fact?

Yes No N/A 4. If offered to you and your dependents, did you elect to continue your prior employer sponsored insurance plan coverage under COBRA or a similar state continuation law?

Yes No N/A 5. If you or your dependents elected COBRA or state continuation, has that coverage, or will it soon be, exhausted?

Yes No N/A 6. Have you or your dependents had less than a 63-day break in coverage from the most recent employer sponsored plan?

If you answered **No** to **ANY** of the above questions, the pre-existing condition limitation **MAY** apply to you and any dependents. If you answered **Yes** to **ALL** of the above requirements you or your dependents qualify as a HIPAA eligible person; as a result: 1) we **MAY** waive the pre-existing condition limitation for you and your dependents as allowed by state law, and we will advise you accordingly; or 2) you or your dependents may qualify for a state-sponsored plan. If (2) applies in your or your dependents state, we will advise you or your dependents on how to enroll in the state plan. IF YOU ANSWERED YES TO ALL OF THE ABOVE REQUIREMENTS PLEASE ATTACH A CERTIFICATE OF CREDITABLE COVERAGE FROM THE PRIOR PLAN, OR ANY OTHER DOCUMENTS TO PROVE THAT YOU OR YOUR DEPENDENTS HAD PRIOR COVERAGE.

Yes No 7. Are you or your dependents buying this insurance to replace prior **group health** coverage? If no, the pre-existing condition limitation will apply. If yes, according to state law: 1) we may waive the pre-existing condition limitation for you and any dependents; or 2) you may qualify for a state-sponsored plan. If 2) applies in your state, we will advise you on how to enroll in the state plan. If yes, you must also attach a Certificate of Creditable Coverage from the prior plan and complete all of the following:

Prior employer sponsored coverage effective date: _____ Prior employer sponsored coverage termination date: _____ Reason for prior coverage termination: _____

Who was covered? _____ Prior coverage was provided by: your employer sponsored plan spouse's employer sponsored plan

Give name of prior insurance company, policy/certificate number, address, and phone number: _____

Yes No 8. If prior coverage was in effect for less than 18 months, did you or your dependents have any preceding health coverage? If yes, was the coverage provided by:

your employer group plan spouse's employer group plan individual policy you purchased for yourself other: _____

Give name of insurance company and policy/certificate number: _____

Who was covered? _____

Terms and Conditions of Insurance

The Applicant shall furnish to the Insurer any information required for the Insurer to administer the Insurance. The Applicant shall have records available for the Insurer to inspect at any time while insurance is in force, and for up to the earlier of three years after termination date, or final adjustment and settlement of claims is made. The Insurer reserves the right to waive or change any of the above requirements at any time.

INSURER UNDERWRITING REQUIREMENTS

The Applicant is required to submit an Application for Insurance for self and/or for all eligible Dependents to be insured. **Insurance for any person is not effective until the date specified by the Insurer.** Depending upon the law, the Insurer may have the right to decline the Application for any person for whom information has been submitted in the Application. We will waive the pre-existing limitation for conditions disclosed on this application, but we may place an exclusion rider on certain condition(s).

TERMINATION OF INSURANCE

The Applicant may terminate insurance at any time by providing the Insurer with written notice prior to the requested termination date. The Insurer will terminate insurance if the Applicant fails to pay premium on the due date, except that coverage continues for a grace period of 31 days after the premium due date. The Applicant may be responsible to pay premium for the grace period coverage. If before any premium due date the Applicant provides advance written notice to the Insurer of request to cancel, then the grace period coverage does not apply. In addition to reasons for termination that are specified in the group insurance Policy, the Insurer may also reform or rescind for fraud or material misrepresentation. The Insurer will provide the Applicant with a minimum of 31 days advance written notice of termination date (unless due to nonpayment of premium, fraud or misrepresentation). Termination will not prejudice a valid claim existing on the termination date, unless due to nonpayment of premium, fraud or misrepresentation.

Upon termination, Applicant may request reinstatement of coverage by paying all applicable premium, plus a nonrefundable reinstatement fee when allowed by state law. Insurer will deposit payment during review of Applicant's request. Depositing Applicant's check does not mean acceptance and does not guarantee reinstatement. Insurer can approve or decline reinstatement request and will notify Applicant in writing.

To be a valid application, your signature and the date you sign it are required. Signature Required-Applicant Agreement/Authorization to Release Medical Information

I understand that the above answers will be relied upon by United Wisconsin Life Insurance Company, ("the Insurer") in the issuance of a certificate of insurance. I declare all statements contained in this entire form about myself and my dependents to be insured are true and correct to the best of my knowledge and that no material information has been withheld or omitted. I understand and agree that the Insurer is not bound by any statement made by or to any agent unless written herein. **I agree that no insurance will be effective until the date specified by the Insurer in the certificate of insurance. The actual effective date may not be the requested effective date.**

To assist American Medical Security, Inc. (AMS) with determining my creditable coverage, I authorize any insurance company, third party administrator, or other authorized carrier, to release to AMS, third party administrator for Insurer, certificates of creditable coverage and all such information.

State law may require a group health plan to follow rules for use of Medical History, rating, renewability and replacement of prior coverage, when the plan is issued to a self-employed individual, a sole proprietor, an independent contractor, a partner, or a sole employee of a Subchapter S or Chapter C Corporation. If such law applies to my state of residence, the agent has advised me about the law and I hereby certify that I do not qualify for such group health plan.

I hereby authorize any physician, medical practitioner, hospital, clinic, veterans administration facility, medical information service, urgent care facility, other medical or medically related facility or entity, insurance or reinsurance company, or Consumer Reporting Agency, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including drug or alcohol abuse, and/or treatment of me or my dependents and other nonmedical information of me or my dependents, to release to AMS and/or Insurer, or its designee any and all such information. I hereby authorize, on behalf of myself and my dependents, that information obtained may be used by the Insurer, AMS or its designee and may be released to reinsuring companies, physicians, medical practitioners, hospitals, clinics, veterans administration facilities, or medically related facilities or other persons or organizations performing business, medical or legal services in connection with the coverage for any claim, medical management purpose or pharmacy benefit management purpose (including the release of claims and medical information by Insurer, AMS or its designee to treating physicians regarding potential problematic drug use patterns) or as may be otherwise lawfully required or as I may further authorize. I agree that a photographic copy of these authorizations shall be as valid as the original, and that these authorizations shall be valid for the maximum length of time permitted by law. I understand the information obtained by use of these authorizations may also be used by the Insurer, AMS or its designees to determine eligibility for insurance, or health coverage, and eligibility for benefits under an existing policy/certificate of insurance, for myself and my dependents. I understand that I may request a copy of this authorization at any time.

Any person who, knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I, the applicant, give permission/authorization to release any medical information (including physical or mental conditions or alcohol or drug abuse) regarding my insurance to _____ (Usually a spouse, parent, or legal guardian) (Name & Relationship) (This may be left blank).

I also hereby acknowledge receipt of the notice "Protecting Your Privacy". I understand that I may request an additional copy at any time.

Do you understand that the company will not pay benefits during the first 12 months of the policy for hospitalization caused by any medical condition or illness you may now have or have had in the past? Yes No

Applicant Signature **X** _____ Date _____

(for EarlyCare, signature must be child's parent or legal guardian, if applicant is not of legal age)

Spouse Signature **X** _____ City & State _____

(Required if spouse is to be insured)

Regional Office _____

Agent Name _____

Address _____

Phone () _____ Fax () _____ Identification No. _____

I certify that I delivered the notice "Protecting Your Privacy" to this applicant, as required by law.

Licensed Agent Signature **X** _____

