

MEMBER APPLICATION TO TAXPAYERS NETWORK INC.



New/Existing Member Information — Name of Member Paying Dues

Name: _____ Social Security Number: _____

Business Name (if applicable): _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____ Fax: _____

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:**

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.



P.O. Box 19032, Green Bay, WI 54307-9032
(920) 661-6020

Pennsylvania Member Application for Group Insurance



P.O. Box 19032, Green Bay, WI 54307-9032
(920) 661-1111 • (800) 232-5432

New application Change in Benefits (specify requested date below in Coverage Information)

This application is to be completed by the applicant applying for coverage. For EarlyCare, application is to be completed by the child's parent or legal guardian if child is not of legal age.

Applicant Social Security Number

Group No.

Applicant/Person to be covered for EarlyCare

Last Name		First Name		Initial	
<input type="checkbox"/> Single <input type="checkbox"/> Married	Address	City	State	ZIP	County
Home Phone No.	Best time to Call	Work Phone No. (if applicable)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Height Weight
Applicant Occupation: _____					
Beneficiary Name (for EarlyCare, Payer is automatic beneficiary)		Last	First	Initial	Relationship
Premium Payer Name (for EarlyCare if not Applicant)		Last	First	Initial	Home Phone No.
Premium Payer Billing Address (for EarlyCare if not Applicant)		City	State	ZIP	County

Dependent Information (If more space is needed, attach an additional sheet of paper, sign and date it.)

First Name & M.I. (last name if different)	Gender	Date of Birth	Height/Weight	Social Security No.	Primary Care Physician's Name
Spouse:	<input type="checkbox"/> M <input type="checkbox"/> F		/		
Spouse's Occupation: _____					
Child:	<input type="checkbox"/> M <input type="checkbox"/> F		/		
Child:	<input type="checkbox"/> M <input type="checkbox"/> F		/		
Child:	<input type="checkbox"/> M <input type="checkbox"/> F		/		
Dependents (age 19 and older) attending school full-time, include name of dependent, name/address of school, and number of credits: _____					

Eligibility

Yes No Are you or any family members covered by Medicare/Medicaid? If yes, list family members and their effective date: _____

Yes No Are you or any family members pregnant (including spouse not applying for coverage)? _____

Yes No Are you or any eligible dependent disabled or hospital confined? _____

Yes No Do any family members intend to keep other insurance coverage in addition to coverage under this policy? If yes, list family members: _____

List the name of the other insurance company(ies) and the policy number(s): _____

Yes No Are you or any family members currently eligible for or receiving COBRA or State Continuation benefits? If yes, list names, eligibility dates, and date benefits end: _____

Yes No Are you a U.S. citizen? If no, list how long in the U.S.: _____ (Attach copy of valid permanent resident card)

Coverage Information

Benefit Options: (Only available with medical coverage)

<p>Medical: <input type="checkbox"/> Applicant <input type="checkbox"/> Applicant/Family <input type="checkbox"/> Applicant/Spouse <input type="checkbox"/> Applicant/Child(ren) <input type="checkbox"/> Child only</p> <p>Requested effective date _____ (Effective date may not be guaranteed)</p> <p>Network Name _____ Product Name _____</p> <p>Deductible/Copay _____ Coinsurance _____</p> <p>Upon signature of this application, I am indicating that I have selected the plan design within the Coverage Information section and that I fully understand the benefit levels of this plan.</p> <p><input type="checkbox"/> I am a HIPAA Eligible Individual under Public Law 104-191 as defined in the Prior coverage section on page 3 of this application but I choose to apply for a Non-HIPAA Eligible medical plan selected. I understand there is no guarantee of policy issuance and that the pre-existing condition limitations of the selected plan will apply regardless of my status as a HIPAA Eligible person.</p> <p>The HIPAA Eligible guarantee issue plan is the carrier of last resort.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No Supplemental Accident Benefit</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Term Life/AD&D Insurance (If applicable)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Dependent Life (If applicable)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Optional Term Life and AD&D Insurance Benefit (\$10,000 min. - \$300,000 max.) Indicate amount: _____</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Optional Dental Plan Plan Selected: _____</p> <p>Prescription Drug: _____</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other _____</p>
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Home Office Use Only

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, ridered, rescinded, or rated up for medical, disability, or life insurance with another insurance carrier? If yes, explain: _____
- B. Yes No In the past five years, 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 Are you or any person to be insured currently taking any prescription medication, over-the counter medication, or vitamin therapy? Please indicate the reason for use: _____
- D. Yes No In the past five years, 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: _____
- E. 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: _____
- F. Yes No Has anyone to be insured used tobacco products during the previous 12 months? If yes, list names: _____
- G. Within the past five years, has any person to be insured ever had any symptoms that would cause an ordinarily prudent person to seek medical care; had any conditions, diagnosis, consultation, routine follow-up, treatment, therapy, been prescribed any medication, been monitored, or received counseling for any of following?... (Provide details to "Yes" answers below.)

- | | |
|--|---|
| <ul style="list-style-type: none"> 1. Abnormal Test Results..... <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Acne..... <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Alcoholism/Alcohol Abuse..... <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Allergies..... <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Arthritis/Pain Disorder..... <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Asthma/Respiratory/Sleep Apnea..... <input type="checkbox"/> Yes <input type="checkbox"/> No 7. Back/Muscle/Joints..... <input type="checkbox"/> Yes <input type="checkbox"/> No 8. Blood Abnormality..... <input type="checkbox"/> Yes <input type="checkbox"/> No 9. Bone Disease/Deformity..... <input type="checkbox"/> Yes <input type="checkbox"/> No 10. Breast Condition/Implants/Fibrocystic Breast Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No 11. Cancer/Leukemia/Hodgkin's/Lymphoma..... <input type="checkbox"/> Yes <input type="checkbox"/> No 12. Cholesterol, elevated..... <input type="checkbox"/> Yes <input type="checkbox"/> No 13. Colitis/Spastic Colon/Polyps..... <input type="checkbox"/> Yes <input type="checkbox"/> No 14. Congenital Abnormality..... <input type="checkbox"/> Yes <input type="checkbox"/> No 15. Cystic Fibrosis..... <input type="checkbox"/> Yes <input type="checkbox"/> No 16. Diabetes/Pancreas..... <input type="checkbox"/> Yes <input type="checkbox"/> No 17. Digestive System..... <input type="checkbox"/> Yes <input type="checkbox"/> No 18. Drug or Substance Addiction/Illicit Use..... <input type="checkbox"/> Yes <input type="checkbox"/> No 19. Ear/Throat/Mouth..... <input type="checkbox"/> Yes <input type="checkbox"/> No 20. Eating Disorder-Anorexia, Bulimia, Other..... <input type="checkbox"/> Yes <input type="checkbox"/> No 21. Emphysema/Lung/COPD/Tuberculosis..... <input type="checkbox"/> Yes <input type="checkbox"/> No 22. Endocrine System or Hormonal Disorder..... <input type="checkbox"/> Yes <input type="checkbox"/> No 23. Epilepsy/Seizure..... <input type="checkbox"/> Yes <input type="checkbox"/> No 24. Eye or Cataracts..... <input type="checkbox"/> Yes <input type="checkbox"/> No 25. Esophageal Disorder/ Gastric Reflux..... <input type="checkbox"/> Yes <input type="checkbox"/> No 26. Fracture/Dislocation/Internal Fixation..... <input type="checkbox"/> Yes <input type="checkbox"/> No 27. Gallbladder..... <input type="checkbox"/> Yes <input type="checkbox"/> No 28. Headaches/Migraines..... <input type="checkbox"/> Yes <input type="checkbox"/> No 29. Heart/Murmur/Palpitations..... <input type="checkbox"/> Yes <input type="checkbox"/> No 30. Heart Valve/Mitral Valve Prolapse..... <input type="checkbox"/> Yes <input type="checkbox"/> No 31. Hepatitis/Liver..... <input type="checkbox"/> Yes <input type="checkbox"/> No 32. Hernia..... <input type="checkbox"/> Yes <input type="checkbox"/> No 33. High Blood Pressure/Hypertension..... <input type="checkbox"/> Yes <input type="checkbox"/> No | <ul style="list-style-type: none"> 34. Infertility Testing/Treatment..... <input type="checkbox"/> Yes <input type="checkbox"/> No 35. Lupus/Systemic or Discoid..... <input type="checkbox"/> Yes <input type="checkbox"/> No 36. Lymphadenopathy/Immune System..... <input type="checkbox"/> Yes <input type="checkbox"/> No 37. Menstrual Disorder..... <input type="checkbox"/> Yes <input type="checkbox"/> No 38. Mental/Nervous/Psychological..... <input type="checkbox"/> Yes <input type="checkbox"/> No 39. Mental Retardation/Down's Syndrome..... <input type="checkbox"/> Yes <input type="checkbox"/> No 40. Multiple Sclerosis..... <input type="checkbox"/> Yes <input type="checkbox"/> No 41. Muscular Dystrophy/Cerebral Palsy..... <input type="checkbox"/> Yes <input type="checkbox"/> No 42. Neurological Disease/Disorder/Impairment..... <input type="checkbox"/> Yes <input type="checkbox"/> No 43. Osteoporosis/Osteopenia/Bone-Thinning..... <input type="checkbox"/> Yes <input type="checkbox"/> No 44. Ovarian Cysts..... <input type="checkbox"/> Yes <input type="checkbox"/> No 45. Pap Smear, abnormal..... <input type="checkbox"/> Yes <input type="checkbox"/> No 46. Paralysis..... <input type="checkbox"/> Yes <input type="checkbox"/> No 47. Prostate..... <input type="checkbox"/> Yes <input type="checkbox"/> No 48. Rectum Colitis/Irritable Bowel/Other Intestinal Disorder..... <input type="checkbox"/> Yes <input type="checkbox"/> No 49. Reproductive Organs..... <input type="checkbox"/> Yes <input type="checkbox"/> No 50. Sexually Transmitted Diseases..... <input type="checkbox"/> Yes <input type="checkbox"/> No 51. Sinus..... <input type="checkbox"/> Yes <input type="checkbox"/> No 52. Skin/Growth/Lesion/Abnormality..... <input type="checkbox"/> Yes <input type="checkbox"/> No 53. Spinal Disorder..... <input type="checkbox"/> Yes <input type="checkbox"/> No 54. Stroke..... <input type="checkbox"/> Yes <input type="checkbox"/> No 55. Systemic Infection..... <input type="checkbox"/> Yes <input type="checkbox"/> No 56. Thyroid/Goiter..... <input type="checkbox"/> Yes <input type="checkbox"/> No 57. Transplants..... <input type="checkbox"/> Yes <input type="checkbox"/> No 58. Tuberculosis..... <input type="checkbox"/> Yes <input type="checkbox"/> No 59. Tumors/Growths/Cysts/Fibroids/Lesions..... <input type="checkbox"/> Yes <input type="checkbox"/> No 60. Ulcerative Colitis/Crohn's/Regional Ileitis..... <input type="checkbox"/> Yes <input type="checkbox"/> No 61. Ulcers-Digestive/Skin/Other..... <input type="checkbox"/> Yes <input type="checkbox"/> No 62. Urinary Tract/Bladder/Kidney..... <input type="checkbox"/> Yes <input type="checkbox"/> No 63. Uterine Fibroids..... <input type="checkbox"/> Yes <input type="checkbox"/> No 64. Vascular Abnormality/Poor Circulation..... <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 1. Have you or your dependents had a total of 18 or more months of prior creditable 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 reasons other than 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

You may terminate insurance at any time by providing us written notice prior to the requested termination date. The termination date will be the first of the month. Insurance will terminate at 12:01 A.M. central standard time on the 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

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 me 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 with determining my creditable coverage, I authorize any insurance company, third-party administrator, or other carrier or provider of health benefits to release to the 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.

Any person who, knowingly and with intent to defraud any insurance company, submits an application or files a claim containing any materially false information may be found guilty of insurance fraud, which is a crime, in a court of law and may be subject to fines and confinement in prison. This will not be considered as a complete application unless all pages are attached and completed.

- I also hereby acknowledge receipt of the "Protecting Your Privacy" and "Protecting Your Health Information" notices. I understand that I may request an additional copy of these notices 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 that has not been disclosed on this application? Yes No

Applicant Signature X _____ Date _____

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

If signed by a representative of applicant, please indicate the representative's authority to act on behalf of applicant. _____

Spouse Signature X _____ Date _____

(If spouse is to be insured)

Regional Office _____

Agent Name _____

Address _____

Phone () _____ Fax () _____ Identification Number _____

I certify that I delivered the "Protecting Your Privacy" and the "Protecting Your Health Information" notices to this applicant, as required by law.

Licensed Agent Signature X _____

Signature Required/Authorization To Release Medical Information For Underwriting

Please clearly print all information.

I hereby authorize those physicians, medical practitioners, hospitals, clinics, veterans administration facilities, medical information services, urgent care facilities, and other medical or medically related entities, insurance or reinsurance companies, and consumer reporting agencies that have information available as to the present or former physical health condition, including drug or alcohol or domestic abuse, and/or treatment of me or my dependents to release any and all such information, including, but not limited to, medical records, health-care provider notes, laboratory tests and results, diagnoses, treatment, and prognoses. I understand the information obtained by use of this authorization may be used to determine eligibility for issuance of health coverage and eligibility for benefits under an existing policy/certificate of insurance for me and my dependents. This authorization is not applicable to psychotherapy notes.

I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall expire 15 months after the termination of any coverage I obtain. I understand that I may request a copy of this authorization. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on my authorization. Because this authorization is given as a condition of obtaining insurance coverage, my revocation will not prevent the Insurer from the right to contest a claim under the policy if another law so allows. Should me or my dependents refuse to sign this authorization, I understand it may affect my enrollment in the benefit plan. All pages must be attached and complete, including this authorization for the application to be considered complete. Incomplete applications may be rejected.

Customer Signature X _____ Date _____
(For EarlyCare, signature must be the child's parent or legal guardian if customer is not of legal age.)

If signed by a representative of applicant, please indicate the representative's authority to act on behalf of applicant.

Spouse Signature X _____ Date _____
(If spouse is covered)

Signature of Each Covered Dependent Age 18 and over:

X _____ Date _____

X _____ Date _____

X _____ Date _____

X _____ Date _____

METHOD OF PAYMENT

Please Select the Method of Payment

Monthly Check-O-Matic Credit Card Monthly Direct Bill (if available) Quarterly Direct Bill

Credit Card Authorization — Please Print Clearly (Not available in Ala., Ga., or Kan.)

VISA MasterCard Discover

I authorize American Medical Security, Inc. (AMS) to bill my credit card account for the total amount due. This authority is to remain effective until I provide AMS with written notification of cancellation. I understand that adequate time will be needed to implement any action.

Applicant Name: _____

Cardholder Name: _____

Credit Card Number: _____ Expiration Date: _____

City: _____ State: _____

Phone: _____

→ Signature of Cardholder: _____

Check-O-Matic Authorization

Applicant Name: _____ Group Number: _____

Payer Name: _____ Relationship to Applicant: _____

Name of Depositor: _____

Print exact name as it appears on financial institution records.

Address: _____

Phone: _____

I (we) hereby authorize American Medical Security, Inc. to initiate debit entries to my (our) checking account and the Financial Institution named below to debit the same to such account. American Medical Security, Inc. will not be held responsible for a policy lapse or cancellation due to nonpayment if the withdrawal is presented and not honored for any reason and the amount due is not paid.

Financial Institution Name: _____ Branch: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____

This authority is to remain effective until I (we) provide AMS and the financial institution with written notification of cancellation. I (we) understand that adequate time will be needed to implement any action.

Names: _____

→ Signature: _____

Date: _____

If the VISA/MasterCard/Discover request for payment is declined, or the Check-O-Matic or direct payment by check transactions is returned for non-sufficient funds, a \$25 nonrefundable service fee will be applied when allowed by state law. All total costs will be withdrawn the first of the month.

Attach a voided check here

PROTECTING YOUR

HEALTH INFORMATION

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.

American Medical Security Group, Inc., affiliates, and subsidiaries, collectively AMS*, responsibly use your individually identifiable health information (referred to as "confidential information"). Confidential information includes information that is created or received by a health-care provider, health plan, employer, or health-care clearinghouse. It also includes information related to your past, present, or future physical/mental health and payment for the provision of your health care.

AMS may use and/or disclose your confidential information without your authorization for the following purposes:

- Rating and other activities relating to the placement or renewal of health benefits.
- Billing, claims payment, review of health-care services, and the management of health-care and related services by health-care providers.
- Providing appointment reminders or information about treatment alternatives, other health-related benefits, and services.
- Providing treatment (coordination and management of health-care related services), payment, or health-care operations.

We may also use and/or disclose your confidential information without your authorization as permitted or required by law (e.g., to a public health authority or Food and Drug Administration; or for the purposes of public health intervention or investigation; evaluation relating to the medical surveillance of the work place; work-related illnesses or injuries; civil, administrative, or criminal investigations and/or inspections; judicial and administrative proceedings; local, state, and federal law enforcement purposes). We may also use it for disclosures to the sponsor of a group's health plan, health insurance issuer, or HMO.

Your *authorization is required* for AMS to use your confidential information to determine eligibility for enrollment and continued eligibility under your health plan. An authorization must also be submitted if you choose to appoint individuals, other than those allowed by law, to receive information about you. You may revoke the authorization in writing at any time unless we are acting or have acted in reliance on an existing authorization from you.



*AMS includes a third-party administrator, American Medical Security, Inc.; an insurer, United Wisconsin Life Insurance Company; and their affiliates. It also includes contracted and non-affiliated entities, Carolina Benefit Administrators, Inc., Health Plan Administrators, Inc., and AMS Benefit Administrators and Insurance Services.

NO-0459-00-H-00 1/03

You have the right to:

- Request an alternate address or other method of contact if you believe that sending your confidential information to its original location may endanger you.
- Inspect and copy your confidential information.
- Request restriction on certain uses or disclosures; however, these restrictions are subject to agreement by AMS.
- Receive an accounting of the disclosures we make involving your confidential information.
- Amend your confidential information (in limited situations).

AMS will maintain the privacy of confidential information as required by law and by the notice currently in effect. AMS is also required to provide this notice of our legal duties and privacy practices related to protected health information. This notice is effective April 1, 2003. We reserve the right to make changes or revisions to the terms of this notice and will send you a new notice if any material changes are made.

If you believe your rights have been violated, you may contact AMS or the secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint. You may send information to either party at the appropriate address listed below:

American Medical Security, Inc.
Attn: Customer Service Department/Privacy Officer
P.O. Box 19032
Green Bay, WI 54307-9032

Department of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C. 20201

You have the right to receive another paper or electronic copy of this notice. To request another copy or to get more information, you may call AMS at:

(800) 232-5432, Ext. 15201

Or visit the Web site at:

www.eAMS.com

Customer service representatives are available 24 hours a day, 365 days a year.

PROTECTING YOUR PRIVACY

American Medical Security Group, Inc. (AMS)* strives to protect the personal financial information of current and former customers.

We want you to know that the information you provide is safe and used responsibly. To maintain the level of service you expect from AMS, we may need to share limited personal financial information within our family of companies and with selected business partners.

You can be certain that protection of your personal financial information is one of our priorities.

Safeguards in Place at AMS

We use data encryption and storage technology that protect your sensitive personal information. At AMS, we have administrative, technical, and physical safeguards in place to ensure privacy.

These include:

- Policies and procedures for handling information.
- Limited access to facilities where information is stored.
- Requirements for third parties to contractually comply with privacy laws.
- Continuous review of company security practices.

We provide training on confidentiality and customer privacy to ensure employees are dedicated to keeping your personal information safe and secure.

Your Protection on the Internet

We collect limited data from our Internet site, such as the date, time, and areas of our site that are visited. This general information helps us improve our site and makes it easier and more convenient for you to use.

If we ask for personal information on the website, you will enter a "secure" mode. The following security features keep your data safe:

- A secure server using 128-bit encryption and authentication technologies, verified by Verisign, Inc. (a leading provider of secure, online certificates).
- Site design to limit display of customer information to only what is necessary.
- Specific user names and passwords to protect sensitive information.

Types of Information We Gather and Use

In administering health benefit plans, we gather and maintain information that may include nonpublic personal information:

- From applications, supporting documents, and other forms (e.g., phone/Social Security/account numbers, income, and employment history).
- About your transactions with us or our affiliates (e.g., payment history and other account information).
- From business partners, vendors, and service companies (e.g., payment processing center or credit union).
- From health-care providers, insurance companies, and third-party administrators (e.g., medical records, claim payment information).

At times, we need to disclose your nonpublic, personal information to our business partners as necessary to affect, administer, or enforce our transactions with you. We may also share all of this information with companies that perform services on our behalf, provided they contractually agree to keep the information confidential.

In Certain States, You May Be Able to Access and Correct Personal Information

You may have the right to access and correct personal information we have collected about you. Personal information includes information that can identify you (e.g., your name, address, Social Security number, etc.).

Our Commitment to You

You're a valued customer, and the information you provide to us is safe and used responsibly. We'll continue to maintain your privacy and provide you with information about how we share your non-public personal financial information.

If you have questions about our privacy guidelines, please call us toll-free at:

(800) 232-5432, Ext. 15201

Or visit the website at:

**www.eAMS.com
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