



ASSURANT Health

# Short Term Medical Health Insurance

## WEST VIRGINIA

### Coverage for 30 – 365 Days

## Simple. Fast. Affordable.

These three words are the reasons why you should never go without health insurance, even for a short time. Short Term Medical insurance is:

**Simple** – You get coverage for unexpected illnesses and accidents; pre-existing medical conditions and routine doctor visits aren't covered.

**Fast** – Coverage can be obtained as early as the next day... just a few simple medical questions to answer.

**Affordable** – You design the plan that best meets your needs and budget. Short Term Medical insurance is a low-cost option for your temporary need and is also a low-cost alternative to COBRA.

### Temporary Health Insurance for People Who Are:

- Between jobs or laid off
- Looking for a lower-cost alternative to COBRA
- Recent college graduates
- Waiting for employer-sponsored coverage
- Temporary or seasonal employees

### Who's Eligible for This Plan?

- Healthy individuals between the ages of 30 days and 64 years, 11 months, who have a temporary insurance need.
- Dependent children through age 18 (age 24 if full-time student) may be covered as dependents on their parent's plan.
- Foreign residents living in the U.S. for at least one year at the time of enrollment, with proof of Alien Registration Receipt Card, visa or other appropriate documentation.

Short Term Medical insurance is often a lower cost alternative to COBRA. To preserve your rights to guaranteed health insurance and coverage for pre-existing conditions, you may need to purchase up to 18 months of COBRA. You may forego these rights when you purchase a Short Term Medical plan or choose to go without insurance.

### Plan Highlights

- Freedom to choose your own doctors and hospitals
- Prescription drug coverage
- In-hospital and out-patient benefits
- Coverage continues beyond the policy period for up to 90 days if you are hospitalized — at no additional cost
- \$1,000 extension of benefit beyond the policy period for up to 60 days for a non-disabling condition — at no additional cost

### Design the Plan That's Right for You

- **Length of coverage options:** Choose anywhere from 30-365 days
- **Deductible option:** \$500, \$1,000, \$2,500 or \$5,000

If the \$500 or \$1,000 deductible option is selected, a covered person needs to satisfy a deductible before benefits are paid. Families of 3 or more people will only need to satisfy a maximum of three deductibles.

**One Family Deductible** — only one deductible needs to be satisfied by all covered family members if the \$2,500 or \$5,000 deductible option is selected.

- **Rate of payment options (coinsurance):** 80/20 or 50/50
- **Lifetime maximum benefit options:** \$1 million or \$2 million

### Benefits are Paid as Follows:

FIRST	You pay the deductible and any copays*.	
THEN	80/20	50/50
	You pay 20% of the next \$25,000 up to a maximum of \$5,000.	You pay 50% of the next \$10,000 up to a maximum of \$5,000.
THEREAFTER	We pay 100% of remaining covered expenses up to the plan maximum of \$1 million or \$2 million for each covered person.	

\* Copays: \$150 per emergency room visit and \$500 per in-patient hospital stay.

## Plan Exclusions

**This Short Term Medical plan does not cover:** pre-existing conditions\* (including those not inquired about on the application); dental or optical treatments; routine physical exams; normal pregnancy or childbirth; well child care; interscholastic and intercollegiate sports injuries; expenses incurred outside the United States, its possessions, territories or Canada. **Other exclusions are listed in detail in the policy you will receive when you purchase Short Term Medical.**

*\* Pre-existing Condition: A medical condition due to Sickness or Injury for which the Insured received medical treatment or advice from a provider within the 5-year period immediately preceding the Effective Date of coverage, regardless of whether the condition was diagnosed or not diagnosed; or that produced signs or symptoms within the 5-year period immediately preceding the Effective Date of coverage. The signs or symptoms must have been significant enough to establish manifestation or onset by one of the following tests: The signs or symptoms would have allowed one learned in medicine to make a diagnosis of the disorder; or the signs or symptoms should have caused an ordinarily prudent person to seek diagnosis or treatment. A pregnancy that exists on the day before your Effective Date will be considered a pre-existing condition.*

## When Does Coverage Begin?

Your coverage will begin at 12:01 a.m. the day of your approved effective date, provided the application received is complete\*, meets the requirements for acceptance and the full initial premium is received. The approved effective date is determined by the **later of:**

- Requested effective date on the application;
- Day after the postmark date affixed by U.S. Post Office or day after the metered date on the envelope;
- Day after the application is received at Assurant Health, if legible U.S. Post Office postmark or metered date is not available.

### Waiting Period:

- There is no waiting period for benefits related to accidents.
- There is up to a three-day wait for sickness benefits if you apply for coverage three or fewer days before your effective date.

*\* Applications that do not meet eligibility requirements will be returned to the insured or agent. Incomplete applications may be returned and/or re-dated by Assurant Health.*

## Two Convenient Payment Options

Paying for your Short Term Medical plan is easy with two convenient payment options:

**Single Payment Option:** Ideal if you know the exact number of days coverage is needed. The minimum number of days you may apply for is 30 days, the maximum is 365 days. **No refunds are available after the 10-day free look period.**

**Monthly Payment Option:** Ideal if you are unsure how long you need coverage. This “pay as you go” option gives you the flexibility to continue coverage for as long as it’s needed or simply stop payments and discontinue the plan once your temporary need ends.

- **MasterCard or VISA** — If you pay your initial 35 day premium by MasterCard or VISA, each additional 30 days of coverage will be automatically charged to your account for up to 365 days. If your temporary need ends prior to this date, simply call 1-800-800-5453 and we will stop the automatic account charge.

*Note: Seven days advance notice is required to ensure future account charges are stopped.*

- **Automatic Charge to Checking Account** — If you choose to pay monthly by automatic charge to checking account, you must submit the first 35 day premium via check along with a separate voided check. All subsequent monthly payments will be automatically debited from your checking account for up to 365 days. If your temporary need ends prior to this date, simply call 1-800-800-5453 and we will stop the automatic account charge.

*Note: Seven days advance notice is required to ensure future account charges are stopped.*

- **Check** — If you pay your initial 35 day premium by check, you will be sent a sheet of payment coupons shortly after you receive your policy. Each coupon is for an additional 30 days of coverage.

## Reduce Your Medical Costs

You may be able to reduce your medical bills by using the doctors and hospitals participating in the PHCS Healthy Directions provider network. Simply call 1-800-357-6847 to see if your doctor or hospital is part of PHCS Healthy Directions. Then present your medical identification card, with the PHCS logo on it, at the time of service and your provider will accept the PPO network rate for services.

## Purchasing an Additional Plan

**This Short Term Medical plan is not renewable.**

However, if your temporary need continues beyond your policy period, you may apply for a new plan under the following circumstances:

- No claims were submitted to us while covered under one of our previous Short Term Medical plans, for you or any member of your family who is to be covered
- There has been no significant change in your health

Any previous or current health condition or symptom will be considered a pre-existing medical condition that will not be covered under a new plan. There is no continuous coverage between plans — therefore your new plan will not provide benefits for any condition or symptom which began during a previous plan. In addition, no benefits are available for any period in which you are not covered by our Short Term Medical plan.

To obtain an additional plan, you must complete a new enrollment form. If we approve the new enrollment form, a new plan will be issued.

## Premium Refunds

If you are not 100 percent satisfied with the plan, you may return the policy and identification cards within 10 days of delivery for a premium refund. No questions asked! **After the 10-day free look period, premiums are not refundable.**

*Note: The \$20 application fee and \$10 administration fee are non-refundable.*

# Apply Now!

1. Calculate the premium for the coverage of your choice. Refer to the Premium Calculation Instructions section to the right.
2. Complete all information, sign and date the enrollment form.
3. Detach the enrollment form, insert it in the envelope with your payment and mail it to your agent.

**Checks or Money Orders should be made payable to: Assurant Health.**

If you have any questions, please contact the agent listed on the brochure or call Assurant Health at 1-800-800-5453.

Primary Insured/Spouse Daily Rate Chart				
Age	Deductible			
	\$500	\$1,000	\$2,500	\$5,000
0-14	\$1.96	\$1.68	\$1.26	\$0.98
15-19	2.52	2.10	1.68	1.40
20-24	2.38	2.10	1.54	1.26
25-29	2.24	1.82	1.26	1.12
30-34	2.52	1.82	1.40	1.12
35-39	3.08	2.38	1.68	1.40
40-44	3.36	2.66	1.96	1.54
45-49	3.92	3.36	2.38	1.96
50-54	5.32	4.48	3.36	2.66
55-59	7.28	5.88	4.34	3.50
60-64	9.80	8.12	5.88	4.76

Note: Only use the rates above for the primary insured and spouse. See chart below for dependent child rates.

Dependent Child Daily Rate Chart (See Step 3 in Premium Calculation Instructions)				
	Deductible			
	\$500	\$1,000	\$2,500	\$5,000
Per Child	\$1.68	\$1.54	\$1.12	\$1.05

Zip Code Factor Table	
ZIP CODE	Factor
250-253, 255-257	1.50
All other WV	1.39

*This plan is unavailable to residents of Hawaii, Massachusetts, New Jersey, New York and Vermont.*

**About This Brochure:** This brochure provides a brief description of the important features of this plan. This is not the insurance policy. The actual plan sets forth in detail the rights and obligations of both you and your insurance company. State mandated benefits, if applicable, are incorporated in your policy.

Assurant Health markets products underwritten by Time Insurance Company.

135-WV



Premium Calculation Instructions		
Refer to the Daily Rate and Zip Code Factor Charts on previous panel.		
<b>Step 1.</b> Choose a payment option – single or monthly.	<b>SINGLE PAYMENT</b>	<b>MONTHLY PAYMENT</b>
<b>Step 2.</b> List each applicant's daily rate. Rate chart is set up by age and deductible.* a) Primary Insured rate ..... b) Spouse rate .....	+ _____ + _____ = _____	+ _____ + _____ = _____
<b>Subtotal</b>	= _____	= _____
<b>Step 3.</b> List the per child rate (see chart on previous panel). ..... Enter the number of dependent children. .... Multiply the rate by the number of children.	x _____ x _____ = _____	x _____ x _____ = _____
<b>Subtotal</b>	= _____	= _____
<b>Step 4.</b> Add the subtotals from Steps 2 & 3 .	= _____	= _____
<b>Step 5.</b> Monthly Factor .....	x <u>1.00</u>	x <u>1.30</u>
<b>Subtotal</b>	= _____	= _____
<b>Step 6.</b> Multiply the ZIP Code Factor by the subtotal in Step 5 . . .	x _____	x _____
<b>Subtotal</b>	= _____	= _____
<b>Step 7.</b> Rate of Payment 80/20, enter 1.00 50/50, enter 0.80 .....	x _____	x _____
<b>Subtotal</b>	= _____	= _____
<b>Step 8.</b> Lifetime Maximum Benefit \$1 million, enter 0 \$2 million, add \$0.10 per person ..... # people on policy _____ x .10 = _____ (enter this number)	+ _____	+ _____
<b>Subtotal</b>	= _____	= _____
<b>Step 9.</b> Enter the number of days of coverage ..... Multiply the number of days by the subtotal in Step 8.	x _____	x <u>35</u>
	Minimum is 30 days. Maximum is 365 days.	Subsequent monthly payments will be less as they are based on 30 day increments. To determine future monthly premiums, repeat the calculation using 30 days.
<b>Subtotal</b>	= _____	= _____
<b>Step 10.</b> Fees ..... \$20 application fee + \$10 administration fee = \$30 (non-refundable)	+ <u>30.00</u>	+ <u>30.00*</u>
<b>TOTAL</b>	= _____	= _____ <i>one time fee only</i>
	Enter this amount on the enrollment form in the box marked <b>TOTAL</b> if you want to have a <b>paper policy mailed to you.</b>	
<b>Step 11.</b> \$10 Savings Option .....	- <u>10.00</u>	- <u>10.00</u>
Save \$10 if you choose to accept delivery of your policy via the Internet rather than having a paper policy mailed to you. Simply provide us with your email address on the enrollment form and we'll send you a secured, personalized link to your policy. This link will be available for the duration of your policy.		<i>one time savings only</i>
<b>TOTAL</b>	= _____	= _____
* Choose one deductible amount per policy. * Application fee and administration fee are added to first month's premium only.	Enter this amount on the enrollment form in the box marked <b>TOTAL</b> if you want to accept delivery of your <b>policy via the Internet.</b>	

<b>Short Term Medical Enrollment Form</b>			<b>Time Insurance Company</b>			<b>WEST VIRGINIA</b>			
REQUESTED EFFECTIVE DATE			<b>Note:</b> Effective date is assigned by Time Insurance Company. The effective date is the later of:			CERTIFICATE/POLICY NUMBER			
MONTH	DAY	YEAR							
1. The day after: a) the date this form is signed; b) the date this form is postmarked for mailing to Time Insurance Company; or c) the date we receive your enrollment request by electronic transmission in our home office, OR 2. If dates cannot be determined, the day we receive this form by mail. <b>The agent cannot assign an effective date different than this.</b>									
APPLICANT'S NAME (Print last, first, middle)				GENDER	BIRTH DATE	SOCIAL SECURITY NUMBER			
STREET ADDRESS				CITY, STATE, ZIP CODE					
SPOUSE'S NAME (If to be insured)				GENDER	BIRTH DATE	SOCIAL SECURITY NUMBER			
CHILDREN (NAME) (If to be insured)	BIRTH DATE	NAME		BIRTH DATE	NAME		BIRTH DATE		
1.		2.		3.					
<b>Note: The plan cannot be issued if YES is answered to any questions. Under no circumstances can coverage become effective prior to the date this application is signed.</b>									
<b>Answer the following questions completely and accurately.</b>							<b>Yes</b>	<b>No</b>	
1. Will you or any person to be insured have any other hospital, Major Medical, or group health insurance in force on the effective date of this plan? .....							<input type="checkbox"/>	<input type="checkbox"/>	
2. Have/Are you, your spouse, or any person to be insured:.....							<input type="checkbox"/>	<input type="checkbox"/>	
◆ been denied insurance due to any health reasons that are still present? ◆ now pregnant, an expectant parent, in the process of adopting a child or ◆ over 300 pounds if male, or over 250 pounds if female? ◆ undergoing infertility treatment?									
3. For any of the following conditions within the last 5 years, have you or any person to be insured received any abnormal test results or medical or surgical treatment, or consulted a health care professional, or taken medication for:.....							<input type="checkbox"/>	<input type="checkbox"/>	
◆ heart disorder including but not limited to heart attack or chest pain?			◆ AIDS or tested positive for HIV?		◆ diabetes?				
◆ Emphysema?			◆ stroke, hypertension or high blood pressure?		◆ cancer or tumor?				
◆ Crohn's disease, ulcerative colitis or hepatitis?			◆ kidney disorder, excluding kidney stones?		◆ alcoholism, chemical dependency, drug or alcohol abuse?				
<b>LENGTH OF COVERAGE</b>		<b>DEDUCTIBLE AMOUNT</b>		<b>LIFETIME MAXIMUM</b>		<b>PAYMENT OPTION</b>		<b>RATE OF PAYMENT</b>	<b>TOTAL</b>
<input checked="" type="checkbox"/> Up to 12 months		<input type="checkbox"/> \$ 500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$5,000		<input type="checkbox"/> \$1 Million <input type="checkbox"/> \$2 Million		<input type="checkbox"/> Single Payment: _____ Days <input type="checkbox"/> Monthly Payment		<input type="checkbox"/> 80% <input type="checkbox"/> 50%	
<b>OPTIONAL RIDERS</b> I hereby select these optional benefits:									
<input type="checkbox"/> Mental Illness Benefits				<input type="checkbox"/> Extended Rehabilitation Services					
<input type="checkbox"/> Extended Home Health Care Benefits				<input type="checkbox"/> Temporomandibular Joint or Craniomandibular Joint Dysfunction Benefits					
The undersigned attests that the information above is true to the best of his/her knowledge. The undersigned realizes that any false, or inaccurate statement or misrepresentation in the enrollment form may result in claim denial or contract rescission. Any person who injures, defrauds, or deceives any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. The undersigned understands that the plan applied for will not pay benefits for any expenses incurred on account of any condition which manifested itself before the effective date. The undersigned also understands that this is not a continuation of any previous medical plan, including any prior Short Term Medical plan. If I am self employed or an employee of an employer with 50 or fewer employees, I warrant premiums for this coverage are not: (1) Paid or reimbursed by my employer or, (2) To the best of my knowledge, treated as tax-deductible by my employer or me as related to an employer benefit plan (Internal Revenue Code sections 106,125,162 or 213).									
PRIMARY PHYSICIAN'S NAME (IF ANY)						PRIMARY PHYSICIAN'S TELEPHONE NUMBER			
APPLICANT'S SIGNATURE						TODAY'S DATE			
DAY TELEPHONE NUMBER				EVENING TELEPHONE NUMBER					
FORM 28786-WV									
<b>\$10 Savings Option</b>									
I would like to save \$10 and receive my policy via the Internet. <input type="checkbox"/> Yes <input type="checkbox"/> No						EMAIL ADDRESS			
To receive the \$10 SAVINGS for policy delivery via the Internet, you <u>must</u> provide your email address in the space to the right.									
<b>Payment Information</b>									
For single payment, select one of the following payment methods:									
<input type="checkbox"/> Check <input type="checkbox"/> MasterCard/VISA      Card # <input type="text"/> - <input type="text"/> - <input type="text"/> - <input type="text"/> Exp. Date: ____ / ____      Authorized Amount \$ _____									
<b>When selecting MasterCard/VISA:</b> I authorize Assurant Health to charge my account for the Short Term Medical policy listed above. I understand there will be no refund of premium after the 10-day free look period in the contract. The \$20 application fee and \$10 administration fee are non-refundable.									
For monthly payment, select one of the following payment methods:									
<input type="checkbox"/> Check <input type="checkbox"/> MasterCard/VISA      Card # <input type="text"/> - <input type="text"/> - <input type="text"/> - <input type="text"/> Exp. Date: ____ / ____      Authorized Amount \$ _____									
<input type="checkbox"/> Automatic charge to checking account (Submit first month premium via check along with a voided check.)									
<b>When selecting MasterCard/VISA or Automatic Charge to a checking account:</b> I authorize Assurant Health to charge my account each month for the Short Term Medical policy listed above, until the end of the policy or until I request cancellation in writing. I understand I can request the charge be stopped if I notify Assurant Health seven days in advance of the charge occurring. I also understand there will be no refund of premium after the 10-day free look period in the contract. The \$20 application fee and \$10 administration fee are non-refundable.									
ACCOUNT HOLDER'S SIGNATURE						DATE			
AGENT NAME			AGENT ID #			APP SOURCE			
Products are underwritten by Time Insurance Company.									