



Washington

Accident Coverage

Thank you for applying for Assurant Supplemental Coverage. Review the product brochure so you understand the benefits and limitations of the plan. Talk to your agent to make sure the plan you're applying for is best suited to your needs.

If you are applying for multiple products, you will need to complete a separate application for each one.

Follow these steps to enroll now!

1. Review the plan information in the brochure and with your agent. Determine which coverage is right for you... 24 Hour Coverage or Off-the-job Coverage... Level 1 or Level 2 Benefits.
2. Decide who you want to cover - just you; you and your spouse; you and your children; or you, your spouse and children.
3. Determine which Industry Class you are in. Rates are determined according to the Industry Class of the primary insured. Your agent can help you determine which Industry Class you should use, A, B, C or D/E.
4. Determine the appropriate rate for the coverage you select. You can use the rate sheet or your agent can run an automated quote and attach it to your application.
5. Start the application process by completing information about you and family members you would like to cover. Also complete the Insurance and Health History section.
6. For quick response to your application, fully complete the application with your agent, including:
 - All required questions
 - Requested effective date
 - Signatures
7. Complete the Billing Form indicating the method of payment.
8. **If you are replacing accident or health insurance with the Accident Coverage you are applying for today,** please review and sign the Notice to Applicant Regarding Replacement of Accident and Health Insurance so your agent can submit a copy with the application.
9. Your agent will submit the completed forms and keep you updated on the status of your application.

AGENT: Leave a copy of the Important Notices page with the customer,
fax all other pages to 414.299.6020

Rates can be automatically generated online using EASE.

Get quick pricing information using the rate grid below. Then copy the appropriate rate into the POLICY INFORMATION section on the Accident application.

Online EASE quotes also provide rates for quarterly, semi-annual and annual intervals.

Determine the appropriate Industry Class based on the Primary Insured's employment.

The Industry Class listing can be found in the **Accident Insurance Product and Underwriting Guide** (form number J-77214) posted in the "Find A Form" section on AssurantHealthSales.com

MONTHLY RATES FOR ACCIDENT PLANS						
COVERAGE			Individual only	Individual & Spouse	1-Parent Family	2-Parent Family
INDUSTRY CLASS A	24 Hour Coverage	Level 1	\$11.20	\$17.80	\$20.80	\$27.80
		Level 2	\$13.70	\$21.90	\$25.60	\$34.20
	Off-the-job Coverage	Level 1	\$10.10	\$16.00	\$18.70	\$25.10
		Level 2	\$12.30	\$19.70	\$23.00	\$30.80
INDUSTRY CLASS B	24 Hour Coverage	Level 1	\$14.00	\$21.10	\$22.90	\$29.90
		Level 2	\$17.00	\$25.70	\$27.90	\$36.40
	Off-the-job Coverage	Level 1	\$12.10	\$18.10	\$19.60	\$25.70
		Level 2	\$14.60	\$22.10	\$24.00	\$31.00
INDUSTRY CLASS C	24 Hour Coverage	Level 1	\$19.00	\$24.20	\$24.50	\$31.40
		Level 2	\$22.90	\$32.30	\$31.10	\$39.80
	Off-the-job Coverage	Level 1	\$15.60	\$19.90	\$20.10	\$25.70
		Level 2	\$18.70	\$26.50	\$25.50	\$32.90
INDUSTRY CLASS D/E	24 Hour Coverage	Level 1	\$21.30	\$27.50	\$27.70	\$34.70
		Level 2	\$25.60	\$36.60	\$35.20	\$43.80
	Off-the-job Coverage	Level 1	\$17.10	\$22.00	\$22.10	\$27.70
		Level 2	\$20.50	\$29.30	\$28.10	\$35.00

This Rate Sheet is for use with product brochures and state variations which contain details of Assurant Supplemental Coverage - Accident Coverage. The rates for this accident plan are only valid for plans issued with effective dates from July 17, 2010, and later. Rates quoted more than 30 days in advance of the requested effective date are subject to change and are not guaranteed. Issuance of coverage is subject to approval. This proposal is not an insurance contract. Only the actual contract provisions apply. The effective date of the quote does not guarantee coverage and is subject to change. Rates are based on primary's age as of the effective date of the plan. Final rates may vary. All rates are subject to underwriting approval.

**APPLICATION FORM FOR
ACCIDENT-ONLY INSURANCE**

TIME INSURANCE COMPANY

PLEASE PRINT IN BLACK INK

TYPE OF ACTIVITY

New Change Conversion Reinstatement Policy Number _____

PERSON(S) PROPOSED TO BE INSURED

Last Name	First Name	M.I.	Sex	Birth date MM/DD/YYYY	Social Security #	Height	Weight
(Applicant)							
(Spouse)							

Dependents

Relationship	Last Name	First Name	M.I.	Sex	Birth date MM/DD/YYYY	Full time student
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

Resident Address _____
Street City State ZIP

Email Address _____

Home Phone () _____ Business Phone () _____ Best Time to Call _____

Name of Employer _____ Type of Business _____

Job Title _____

Job Duties _____

■ PROPOSED ADDITIONS TO AN EXISTING POLICY ONLY

Add Spouse named above Add Dependent(s) named above

Reason(s) for addition(s) _____

Desired effective date for addition(s): _____

Complete the POLICY INFORMATION section below to indicate the type of coverage now desired. Complete the remainder of the application respective to any coverage applicable to the proposed addition.

BILLING – to be completed by agent

<u>Payroll Deduction</u>	<u>Direct</u>
<input type="checkbox"/> Monthly <input type="checkbox"/> 28 day	<input type="checkbox"/> Monthly Credit Card <input type="checkbox"/> Monthly EFT (Electronic Fund Transfer)
<input type="checkbox"/> Other	<input type="checkbox"/> Annual Billing

Employee No. _____ Dept. No. _____

Billable Premium \$ _____ Premium Collected \$ _____

Sit. Code _____

POLICY INFORMATION - to be completed by agent

CHECK COVERAGE DESIRED

- Individual only Individual and Spouse
 One-Parent Family Two-Parent Family

Occupation Class _____
 Industry Code _____
 Industry Class A B C D E

				Modal Premium	If Payroll Deduction
<input type="checkbox"/> Level 1 Off the Job Accident Policy <input type="checkbox"/> Level 2 Off the Job Accident Policy <input type="checkbox"/> Level 1 24-hour Accident Policy <input type="checkbox"/> Level 2 24-hour Accident Policy				\$	<input type="checkbox"/> Pre Tax <input type="checkbox"/> After Tax
Optional Rider Coverage	Number of Units*	Disability Benefit Period	Disability Elimination Period	Modal Premium	If Payroll Deduction
<input type="checkbox"/> Off the Job Accident Disability Rider (available for Applicant only)		<input type="checkbox"/> 6 months <input type="checkbox"/> 12 months	<input type="checkbox"/> 0 days <input type="checkbox"/> 7 days	\$	After tax only
<input type="checkbox"/> On the Job Accident Disability Rider (available for Applicant only)		<input type="checkbox"/> 6 months <input type="checkbox"/> 12 months	<input type="checkbox"/> 0 days <input type="checkbox"/> 7 days	\$	
<input type="checkbox"/> Sickness Disability Rider (available for Applicant only)		<input type="checkbox"/> 6 months <input type="checkbox"/> 12 months	14 days only	\$	
<input type="checkbox"/> Spouse Off the Job Accident Disability Rider (available for Applicant's spouse only)		6 months only	0 days only	\$	
*NOTE: Each unit is equal to a \$100 monthly benefit				\$	TOTAL PREMIUM

INSURANCE AND HEALTH HISTORY

- 1a. Are you covered under another accident policy with:
- Time Insurance Company No Yes, policy # _____ No Yes
 - Union Security Insurance Company No Yes, policy # _____ No Yes
 - John Alden Life Insurance Company..... No Yes, policy # _____ No Yes
- Is this a change of that coverage? No Yes

1b. Does this policy replace any other health policy you currently have? Yes No

2. Has anyone proposed to be insured been charged with driving under the influence of alcohol or any narcotic within the last 12 months or been charged two or more times within the last five years? Yes No

If "Yes", please list the name and relationship of each person _____

**Anyone listed in response to 2 will not be covered under the policy or any riders.
If the applicant is listed, a policy will not be issued, in which case do not submit this application.**

3a. Has anyone proposed to be insured been diagnosed with or treated for an injury, disease, or disorder of the back, the neck, or a joint by a member of the medical profession in the last 12 months? Yes No

If you answered "Yes" to 3a, provide the details below and complete 3b.

Person's Name	Medical Conditions	Onset MM/YYYY	Surgery Performed? If "Yes", provide the type of procedure and date

For policies that provide benefits for expenses incurred for an accidental injury only

**IMPORTANT NOTICE TO PERSONS ON MEDICARE:
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE.**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplemental Insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them.

These include: hospitalization; physician services; and, other approved items and services.

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

BEFORE YOU BUY THIS INSURANCE

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

FAIR CREDIT REPORTING ACT AND PRIVACY PRE-NOTIFICATION

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

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

Information collected by us and used to issue an insurance policy or certificate may be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, P.O. Box 624, Milwaukee, WI 53201-0624.

FRAUD WARNING

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

NOTIFICATION REGARDING THE MEDICAL INFORMATION BUREAU

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

BILLING

Complete the details below for the Primary applicant (PLEASE PRINT):

Last Name First Name MI

You have four billing methods to choose from:

1. Monthly payroll deduction (worksite billing)

→ Assigned account number, if known: _____

Note to agent: this option requires the worksite to have 5 or more issued policies and a Worksite Billing Account Agreement Form on file.

2. Electronic Funds Transfer (EFT)/Check-O-Matic → Choose how often: Monthly Quarterly
 Semi-Annual Annual

→ To begin EFT/Check-O-Matic withdrawals:

Select a desired withdrawal day 1-28: _____

Bank Name: _____

City: _____ State: _____

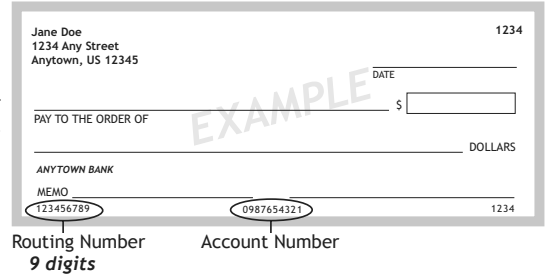
Routing number: _____

Account number: _____

→ To add this policy to an existing EFT/Check-O-Matic:

Existing EFT/COM Number: _____

Associated Policy Number: _____



AUTHORIZATION FOR EFT/CHECK-O-MATIC BILLING – please sign below

I (we) hereby authorize Time Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, indicated above, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Accountholder Signature: _____ Date: _____

3. Credit card → Choose how often: Monthly Quarterly Semi-Annual Annual

AUTHORIZATION FOR CREDIT CARD PAYMENTS – please sign below

I authorize Time Insurance Company to charge my account for the individual supplemental insurance policy. I understand there will be no refund of premium after the 30-day free look in the contract

Card number: _____ - _____ - _____ - _____

Card type: VISA MasterCard

Expiration date: ____/____

Name as it appears on card: _____

Cardholder billing address if different than resident address: _____

Cardholder signature: _____ Date: _____

4. Bill me directly: → Choose how often: Quarterly Semi-Annual Annual

If your billing address is different than your home address, please enter it here:

Billing Address: _____
(Street) (City) (State) (ZIP)

Name of person paying, if different: _____

Time Insurance Company
501 West Michigan
P.O. Box 624
Milwaukee, WI 53201-0624

**NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND HEALTH INSURANCE**

According to your application, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by Time Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

(Date)

(Applicant's Signature)