ASSURANT Health®

Submission Receipt

Name: Sherri Mills
Application Number(s): Dental: 0062593767
Insurance Company: Time Insurance Company
Submitted: 12/16/2015 7:21 PM

Client Instructions

You received a packet of documents from your agent. Please refer to the specific instructions below for each document.

Document Name	Instructions
• Proposal and Plan Summary • Client Summary • Important Notices - Dental	For your records.

Note: This application number does not guarantee coverage. **Do not cancel any existing insurance** until we have received payment and you have received written confirmation that you have been approved for a policy from us.

ASSURANT Health

APPLICANT INFO

State, Zip: 27051, NC
Effective Date: 12/17/2015
Primary: Female, 0
Payment Frequency: Monthly

Plan	To be covered	Plan Options	Premium
Dental	Primary Only	Intermediate Plan	**$21.80**
		Total Monthly Premium	**$21.80**

Agent Information

AGENT NAME: SHIRLEE FEQUIERE
AGENT ADDRESS: 12223 HIGHLAND AVE, STE 106-276, RANCHO CUCAMONG, CA 91739
PHONE NUMBER: (888) 290-9060
FAX NUMBER: (909) 303-3491
EMAIL ADDRESS: SHIRLEE.FEQUIERE@EBROKERCENTER.COM
AGENT NUMBER: AA051665-0-00-301
AGENCY NAME: E BROKER CENTER INC

Dental Intermediate Plan, for Primary Only

- $100/visit for Preventive Services (cleanings, exams, x-rays, fluoride) - up to two visits per person each policy year
- $55 - $375/service for Basic Services (anesthesia, fillings, extractions) - in the first policy year, payments are 50% of the per-service benefit
- $1,000 maximum calendar year benefit for basic services

For Office Use Only:
Applicant Info: Sherri Mills Address: 5140 stoney point rd, Walkertown, NC 27051
Date: 12/16/2015 Version: 12.6.0
Dental Form/Plan ID: 8079/DENT

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company.
501 W. Michigan Milwaukee, WI 53203

ASSURANT Health®

Application Number(s) & Product
0062593767 Dental

Client Summary - Dental

Note: Do not submit to Assurant Health.

Requested Effective Date: **12/17/2015**

AGENT/AGENCY INFORMATION

Agent Name:	SHIRLEE FEQUIERE	Phone Number:	(888) 290-9060
Agent Number:	AA051665-0-00-301	E-mail Address:	SHIRLEE.FEQUIERE@EBROKERCENTER.COM
Agency Name:	E BROKER CENTER INC	Agency Number:	AA049407-1-00-401
Fax Number:	(909) 303-3491	**Insurance Company:**	**Time Insurance Company**

PERSONAL INFORMATION

Relationship	Last Name	First Name	Sex	Age	Birthdate	Social Security Number
Primary	Mills	Sherri	Female	0	02/19/2015	XXX-XX-5340

Resident Address: 5140 stoney point rd (Street) | Walkertown (City) | NC (State) | 27051 (ZIP Code) | Forsyth (County)

Phone Number: (336) 934-2457

Email Address: natvieamerican1963@yahoo.com

Alternate Phone Number:

CURRENT INSURANCE - DENTAL

Is the proposed insured covered by, or has application been made for any type of dental insurance? ☐Yes ☒No

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PAYMENT

Payment Amount: **$21.80**

☒Monthly ☐Quarterly ☐Semi-Annual ☐Annual

Recurring Payment

VISA Card Number: XXXX-XXXX-XXXX-3334
Security Code: XXX
Exp. Date: 11 /2019
Select a desired withdrawal day: 15
Name as it appears on card: Sherri D Mills
Credit/Debit Card Billing Address:

Mailing Address:	5140 stoney point rd	Walkertow n	NC	27051
	(Address)	(City)	(State)	(ZIP Code)

Premium for this policy is being paid for by: ☒Self ☐Family Member ☐Other

AGENT CONTACT INFORMATION

Contact Last Name: FEQUIERE
Contact First Name: SHIRLEE
Contact Phone: (888) 290-9060
Contact Fax: (909) 303-3491
Contact Email: SHIRLEE.FEQUIERE@EBROKERCENTER.COM

SUBMISSION

Information collected from: Parent/Legal Guardian - Sherri D Mills

AGENT ATTESTATION

I, SHIRLEE FEQUIERE, certify that I am the agent who solicited, negotiated, and sold insurance to this applicant.

ATTENTION: AGENT

SHIRLEE FEQUIERE
Licensed Agent's Signature

NOTE:

The quote shown above is based upon the information you provided us and are good for 30 days. The rates contained in these quotes indicate our preferred rates and are not guaranteed. These rates are subject to change based upon your application and medical history, our underwriting requirements, and any additional benefits you may select. You will not receive a final rate until the application process is complete. Please do not cancel any existing medical/dental insurance coverage until you have received written acceptance for coverage from us. You may be subject to a pre-existing condition limitation on benefits. Refer to the certificate of insurance for terms and conditions.

HEALTH HISTORY QUESTIONS

1. Is the Proposed Insured a dentist, dental hygienist, or employed in a dental office or clinic or as an insurance agent?

   ☐ Yes ☒ No

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AUTHORIZATIONS

eSignature Authorization

I consent to complete the plan selection and enrollment electronically. I can update my personal information at any time during the enrollment process or request a non-electronic copy of the enrollment materials by calling 800-596-0049. I can withdraw consent at any time prior to the completion of the transaction by sending a written request to Assurant Health: Attention Enrollment Department, PO Box 624, Milwaukee, WI 53201. I understand that this consent applies only to the submission of this plan selection and enrollment material and if I withdraw my consent, my enrollment may be delayed or cancelled.

I have read the above statements and disclosures and agree to these terms.

☒ Yes

☐ No

Credit or Debit Card Authorization - Supplemental Coverage

I authorize Time Insurance Company to withdraw funds/charge my account as directed in my Payment Information. I agree subsequent payments can be withdrawn/charged until Time Insurance Company has received written notification from me to stop future charges and has a reasonable opportunity to act on the notification.

I have read the above statements and disclosures and agree to these terms.

☒ Yes

☐ No

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FINAL AUTHORIZATION

Dental Authorization

My application form, recorded Authorizations and any amendments shall be the basis for the contract.

The insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company. The effective date is assigned by Time Insurance Company. The premium must be paid when due. A change in the eligibility of the proposed insured(s) after the completion of the application form and before the delivery of the contract may affect my eligibility for insurance with the company. I understand and agree that any information I provide through this application process may be shared with persons necessary to facilitate issuing coverage, including but not limited to my agent or broker.

I understand that this authorization is required in order to enable Time Insurance Company to make eligibility or application determinations relating to me and/or my minor children. If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for insurance. I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization. Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: 30 days after denial of my application, or declination of application, or, if insured, 30 days after when I am no longer an insured of Time Insurance Company. But in no event will this authorization be in effect for longer than 24 months from the date signed.

I agree that a photocopy of this authorization shall be valid for two years from the date signed.

I acknowledge receiving the notification regarding the Abbreviated Notice of Insurance Information Practices and the Outline of Coverage for Health Insurance, if required.

I acknowledge that I have read the completed application form. I attest that all statements and answers on this application form are complete, true and correct. I understand and acknowledge that any fraudulent statement or material misrepresentation or omission on the application form, recorded Authorizations and/or any amendments may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provision of the contract.

Relationship to Primary: Parent/Legal Guardian

Sherri D Mills
(full name)

☒ I Agree
☐ Not Present

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COMMUNICATION PREFERENCES

Go Paperless

Would you like to go paperless and access your policy contract, EOBs (claim information) and more, online through AssurantHealth.com?

☐ YES – I prefer to go paperless and get access to my policy contract, EOBs (claim information) and more online through AssurantHealth.com.

E-mail Address: natvieamerican1963@yahoo.com

☒ NO – I prefer to receive my policy contract, EOBs (claim information) and more by mail.

IMPORTANT NOTICES - LEAVE WITH CUSTOMER

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances 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, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.

FRAUD NOTICE

Any person who provides false, incomplete or misleading facts or information, with the intent to injure, defraud, or deceive an insurer or insurance claimant, is guilty of a Class H felony and may be subject to criminal and civil penalties.

PRIVACY

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on application forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.