TIME INSURANCE COMPANY

Submission Receipt

Name: Shannon Watts
Application Number(s): Dental: 0062607497
Insurance Company: Time Insurance Company
Submitted: 1/16/2016 2:12 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 • Outline of Coverage - 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.

TIME INSURANCE COMPANY

APPLICANT INFO

State, Zip: 74105, OK
Effective Date: 01/17/2016
Primary: Female, 45
Payment Frequency: Monthly

Plan	To be covered	Plan Options	Premium
Dental	Primary Only	Intermediate Plan	**$26.50**
		Total Monthly Premium	**$26.50**

Agent Information

AGENT NAME: MATTHEW BOSAH
AGENT ADDRESS: C/O- GO HEALTH LLC, 9800 S LA CIENEGA BLVD 7TH FLR, LOS ANGELES, CA 90301
PHONE NUMBER: (888) 290-9060
EMAIL ADDRESS: MBOSAH@EXCHANGEADVISERS.COM
AGENT NUMBER: AA025144-0-00-402
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: Shannon Watts Address: 1312 East 60th Street Apartment 1E, Tulsa, OK 74105
Date: 01/16/2016 Version: 12.6.0
Dental Form/Plan ID: 8079/DENT

Products underwritten and issued by Time Insurance Company.
501 W. Michigan Milwaukee, WI 53203

TIME INSURANCE COMPANY

Application Number(s) & Product
0062607497 Dental

Client Summary - Dental

Requested Effective Date: **01/17/2016**

AGENT/AGENCY INFORMATION

Agent Name:	MATTHEW BOSAH	Phone Number:	(888) 290-9060
Agent Number:	AA025144-0-00-402	E-mail Address:	MBOSAH@EXCHANGEADVISERS.COM
Agency Name:	E BROKER CENTER INC	Agency Number:	AA049407-1-00-401
Fax Number:		**Insurance Company:**	**Time Insurance Company**

PERSONAL INFORMATION

Relationship	Last Name	First Name	Sex	Age	Birthdate
Primary	Watts	Shannon	Female	45	09/07/1970

Resident Address: 1312 East 60th Street Apartment 1E (Street) | Tulsa (City) | OK (State) | 74105 (ZIP Code) | Tulsa (County)

Phone Number: (918) 576-6711 Email Address: bootawoota4@gmail.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: **$26.50**

☒Monthly ☐Quarterly ☐Semi-Annual ☐Annual

Recurring Payment

MasterCard Number: XXXX-XXXX-XXXX-4447
Security Code: XXX
Exp. Date: 06 /2019
Select a desired withdrawal day: 15
Name as it appears on card: Shannon Watts
Credit/Debit Card Billing Address:

Mailing Address:	1312 East 60th Street Apartment 1E	Tulsa	OK	74105
	(Address)	(City)	(State)	(ZIP Code)

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

AGENT CONTACT INFORMATION

Contact Last Name: BOSAH
Contact First Name: MATTHEW
Contact Phone: (888) 290-9060
Contact Fax:
Contact Email: MBOSAH@EXCHANGEADVISERS.COM

SUBMISSION

Information collected from: Primary - Shannon Watts

AGENT ATTESTATION

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

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

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 Time Insurance Company: 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

Employer Sponsored Business (ESB) Statement - Dental

You understand and agree that you are applying for dental insurance for you (and your family). You further understand this application for dental insurance is subject to eligibility requirements. You are personally paying the entire premium for this dental insurance coverage.

Your employer is not contributing in any way to the payment of premium, either directly or indirectly.

Do you agree with this statement?

☒ 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

Application Number(s) & Product
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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: Self

Shannon Watts
(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?

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

E-mail Address: bootawoota4@gmail.com

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

Products underwritten and issued by Time Insurance Company, Milwaukee, WI. California license number 8109 (Time Insurance Company).

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

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.

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.

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

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

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

DENTAL INDEMNITY INSURANCE
OUTLINE OF COVERAGE FOR
POLICY FORM 8079.POL.OK

THE POLICY PROVIDES LIMITED BENEFITS

THE POLICY PROVIDES COVERAGE FOR DENTAL BENEFITS ONLY AND
DOES NOT PROVIDE REIMBURSEMENT OF MEDICAL EXPENSES

THIS IS NOT A MEDICARE SUPPLEMENT POLICY

READ YOUR POLICY CAREFULLY: This outline of coverage provides a very brief description of the important features of the Policy. This is not the insurance Policy and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both You and Time Insurance Company. It is, therefore, important that You READ YOUR POLICY CAREFULLY!

DENTAL INDEMNITY COVERAGE: Policies of this category are designed to provide, to the person insured, benefits when specified dental procedures are rendered, subject to any limitations set forth in the Policy and in the amount shown on the Policy Schedule. Coverage is not provided for basic hospital, basic medical-surgical or major medical expenses.

DENTAL COVERAGE INFORMATION

Dental Preventive Benefits: We will pay one Dental Preventive Benefit of $100, regardless of the number of visits to a Dentist or Dental Hygienist or the number of services received, every 150 calendar days. Dental Preventive Benefits are limited to a maximum benefit of $200 per Calendar Year.

Basic Dental Services Benefits: We will pay the Scheduled Benefit for Basic Dental Services as shown on the Policy Schedule. The Scheduled Benefit will be reduced by 50% for all Basic Dental Services rendered during the first Policy Year following the Effective Date of coverage. All benefits for Basic Dental Services rendered during the same Calendar Year are subject to a maximum Calendar Year benefit limitation of $1,000.

EXCLUSIONS AND LIMITATIONS:

This Policy pays limited, fixed indemnity benefits for Dental Treatments only. See the Policy Schedule for the limited benefit amounts and maximum benefit limitations.

We will not pay benefits for any of the following:

1. any procedure or treatment not shown on the Policy Schedule.
2. any procedure rendered during an applicable Benefit Waiting Period.
3. any amount in excess of a Calendar Year or lifetime maximum benefit limitation.
4. Dental Preventive Benefits when there is less than 150 calendar days between the dates of service for Dental Preventive Services.
5. all Experimental or Investigative Services.
6. any procedure performed by a person other than a Dentist or Dental Hygienist.
7. any procedure performed by a Covered Person’s Immediate Family Member.

8. all services that are not Dentally Necessary.

9. repairs to dental work less than 180 calendar days following completion of the initial procedure.

10. prosthetics replaced less than 5 years following the previous placement.

11. crowns replaced less than 5 years following the previous placement.

12. inlays or onlays replaced less than 5 years following the last placement.

13. dental implants or the removal of implants.

14. Cosmetic Services, unless performed to correct a functional disorder.

15. services performed outside the United States and, its territories and Canada except for services that are received for Emergency Dental Treatment.

16. replacement of any tooth missing prior to the Effective Date.

17. placement of full or partial dentures, whether removable or fixed, including a Maryland Bridge, unless replacing a Functioning Natural Tooth extracted after the Effective Date and not within a Benefit Waiting Period.

18. for Covered Persons under age 16, inlays, onlays, bridgework or crowns except for stainless steel or plastic crowns.

19. any charge or procedure for treatment required because of Dental Injury or disease due to:

    a. war or acts of war, whether declared or undeclared, while serving in the military service or any auxiliary unit.
    b. charges for Sickness or Injury caused or aggravated by attempted suicide or self-inflicted Sickness or Injury, even if the Covered Person did not intend to cause the harm which resulted from the action which led to the self-inflicted Sickness or Injury.
    c. taking part in a riot or insurrection, or an act of riot or insurrection.
    d. participating in, voluntarily attempting to commit or commission of a felony, whether or not charged, or engaging in an illegal occupation or activity at the time of an Accident.
    e. voluntary use of any controlled substance, as defined by statute, except when administered in accordance with the advice of the Covered Person's health care practitioner.
    f. riding in any aircraft not licensed to carry passengers or not operated by a duly licensed pilot.
    g. charges for treatment or services required due to an Injury sustained in operating a motor vehicle while the Covered Person's blood alcohol level, as defined by law, was .08 or higher. This exclusion applies whether or not the Covered Person is charged with any violation in connection with the Accident.

20. procedures rendered before the Effective Date or after the termination date of coverage.

21. orthodontic treatment and services.

RENEWABILITY PROVISION: The policy is guaranteed renewable until 12:01 a.m. local time at the Policyholder's state of residence on the earliest of the following dates:

1. the date We receive a request in writing or by telephone to terminate this plan or on a later date that is requested by the Policyholder for termination.

2. the date We receive a request in writing or by telephone to terminate coverage for a Covered Dependent or on a later date that is requested by the Policyholder for termination of a Covered Dependent.

3. the date this plan lapses for nonpayment of premium per the Grace Period provision in the Premium Provisions section.

4. the date there is fraud or material misrepresentation made by or with the knowledge of any Covered Person applying for this coverage or filing a claim for benefits.

5. on the date the Policyholder moves to a state where We do not provide insurance coverage under the same plan as this Policy, We reserve the right to terminate this coverage.

6. for a Covered Dependent: on the date a Covered Dependent no longer meets the Dependent definition in this plan.

7. The anniversary date of this Policy following the Policyholder's 75th birthday.

PREMIUM INFORMATION	
Premium Payment Mode:	MONTHLY
INITIAL MONTHLY PREMIUM AMOUNT:	$26.50
INITIAL ANNUAL PREMIUM AMOUNT:	$318.00

Your premium may be adjusted from time to time based on different factors including, but not limited to, Your geographic area, payment method and plan design. All premium adjustments will be made to individuals on the basis of shared characteristics. The premium may also change if You add or delete Covered Dependents, change the payment method, move to another zip code or otherwise change the coverage.

Licensed Agent's Signature

Date