TIME INSURANCE COMPANY

Submission Receipt

Name: Sarah William
Application Number(s): Accident: 0062616084, Accident Medical Expense: 0062616085, Dental: 0062616086
Insurance Company: Time Insurance Company
Submitted: 2/1/2016 3:37 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 - Accident • Important Notices - Accident Medical Expense • 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.

TIME INSURANCE COMPANY

APPLICANT INFO

State, Zip: 28677, NC
Effective Date: 02/03/2016
Primary: Female, 25
Payment Frequency: Monthly
Industry: All Others

Plan	To be covered	Plan Options	Premium
Accident	Primary Only	Level 2 24 Hour Accident Primary's Industry: All Others	**$18.30**
Accident Medical Expense	Primary Only	Benefit Amount: $3,000	**$12.18**
Dental	Primary Only	Intermediate Plan	**$26.50**
		Total Monthly Premium	**$56.98**

Agent Information

AGENT NAME: SEAN MCCLOSKEY
AGENT ADDRESS: 9518 9TH STREET SUITE C2, RANCHO CUCAMONGA, CA 91730
PHONE NUMBER: (888) 290-9060
FAX NUMBER: (949) 625-0352
EMAIL ADDRESS: HEALTHINSURANCE247@GMAIL.COM
AGENT NUMBER: AA027560-0-00-704
AGENCY NAME: E BROKER CENTER INC

24 Hour Accident Coverage, Level 2 for Primary Only

When you're treated for an accidental injury, Accident benefits help you face the medical cost, extra expenses and loss of income that can come your way.

- Cash benefits add up - benefits are paid for each covered injury and service
- Benefits begin immediately - no waiting period
- Benefits are paid in addition to any other benefits you may receive - helping you replace lost income and pay bills
- No overall annual or lifetime limits - benefits available no matter how many times you need them
- Choose any doctor or hospital - no network restrictions
- Around-the-clock coverage

You could receive benefits from the day of the injury through the recovery period. Here are some examples:

Accident Benefit Examples	Benefit Amount
Concussion	$100
Treatment (emergency room, urgent care or doctor's office)	$100 adult/$50 child, Follow-up Treatment $35
Ambulance (ground/air)	$200/$1,500
Hospitalization	$300/day
ICU Confinement	$500/day
Lodging	$125/night
Blood/Plasma/Platelets	$200
Major Diagnostic Exams	$200
Physical Therapy	$35/day
Prosthesis	$750
Rehabilitation Unit	$150/day
Fractures (closed/open reduction)	Per-service benefit amounts up to $3,750/$5,000
Coma (7 or more days)	$20,000
Paralysis (paraplegia/quadriplegia)	$25,000/$50,000
Accidental Death	$50,000 adult/$20,000 child
Accidental Dismemberment	Up to Accidental Death benefit

$3,000 Accident Medical Expense Coverage for Primary Only

ACCIDENT MEDICAL EXPENSE PLAN BENEFITS

- Accident Medical Expense (AME) Benefits - $3,000 per accident with no limit to number of accidents in a calendar year
- Deductible per accident - $250
- Treatment-specific limitations:
  - Benefits for ground ambulance services - limit of $300 per accident
  - Physical medicine - Maximum benefit of $25 per visit day, up to $250 per accident
  - Durable medical equipment and personal medical equipment - Maximum benefit of $100 per accident

Accidental Death and Dismemberment maximum benefit limitation	All accidental dismemberment benefits and the accidental death benefits combined are limited to $3,000 per accident, based on the selected benefit level
Accidental Dismemberment Benefit	Initial treatment or evaluation of the accidental dismemberment must be received within the first 7 days after the date the accident occurs

Accidental dismemberment	Benefit amount paid
Loss of one hand	$1,500
Loss of one foot	$1,500
Loss of sight of one eye	$750
Loss of hearing in one ear	$750
Loss of speech	$1,500

Accidental Death Benefit

Covered person	Benefit amount paid
Policyholder	$3,000

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: Sarah William Address: 3627 HICKER HWY, Statesville, NC 28677
Date: 02/01/2016 Version: 12.6.0
Accident Form/Plan ID: 8032/ACCD
Accident Medical Expense Form/Plan ID: 8227/AMEP
Dental Form/Plan ID: 8079/DENT

Rates may vary slightly and are not guaranteed. This quote is not an insurance contract. Only the actual contract provisions will apply.

Supplemental products are separate contracts available at an additional cost. Benefits described on this website are a result of purchasing two or more policies.THESE POLICIES PROVIDE LIMITED BENEFITS. This supplemental plan does not provide comprehensive health (major medical) insurance or satisfy the government's requirements for minimum essential coverage.

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

TIME INSURANCE COMPANY

Application Number(s) & Product
0062616084 Accident

Client Summary - Accident

Requested Effective Date: **02/03/2016**

AGENT/AGENCY INFORMATION

Agent Name:	SEAN MCCLOSKEY	Phone Number:	(888) 290-9060
Agent Number:	AA027560-0-00-704	E-mail Address:	HEALTHINSURANCE247@GMAIL.COM
Agency Name:	E BROKER CENTER INC	Agency Number:	AA049407-1-00-401
Fax Number:	(949) 625-0352	**Insurance Company:**	**Time Insurance Company**

PERSONAL INFORMATION

Relationship	Last Name	First Name	Sex	Age	Birthdate	Social Security Number
Primary	William	Sarah	Female	25	12/14/1990	XXX-XX-5305

Resident Address: 3627 HICKER HWY (Street) | Statesville (City) | NC (State) | 28677 (ZIP Code) | Iredell (County)

Phone Number: (704) 380-3248 Email Address: SEW9182@YAHOO.COM

Alternate Phone Number:

Occupation:

Primary Insured Industry: All Others

BENEFICIARY INFORMATION

Name	Address	Relationship	Percentage
Sarah William	3627 HICKER HWY,STATESVILLE,NC,28677	Estate	100

CURRENT INSURANCE - ACCIDENT

Are you covered under another Accident policy with Time Insurance Company? ☐Yes ☒No

Application Number(s) & Product
0062616084 Accident

PAYMENT

Payment Amount: **$18.30**

☒Monthly ☐Quarterly ☐Semi-Annual ☐Annual

Recurring Payment

MasterCard Number: XXXX-XXXX-XXXX-3851
Security Code: XXX
Exp. Date: 06 /2018
Select a desired withdrawal day: 15
Name as it appears on card: Sarah E William
Credit/Debit Card Billing Address:

Mailing Address:	3627 HICKER HWY	Statesville	NC	28677
	(Address)	(City)	(State)	(ZIP Code)

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

AGENT CONTACT INFORMATION

Contact Last Name: MCCLOSKEY
Contact First Name: SEAN
Contact Phone: (888) 290-9060
Contact Fax: (949) 625-0352
Contact Email: HEALTHINSURANCE247@GMAIL.COM

SUBMISSION

Information collected from: Primary - Sarah William

AGENT ATTESTATION

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

ATTENTION: AGENT

SEAN MCCLOSKEY
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.

Application Number(s) & Product
0062616084 Accident

HEALTH HISTORY QUESTIONS

1. What is your current height and weight?

   Sarah William Height: 5 Feet 1 Inches Weight: 140 lbs

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

3. 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

4. Has anyone proposed to be insured been prescribed any medication or taken any prescription medication (not including prescription contraceptives) in the last six weeks?

   If you answered "No" to the previous back/neck/joint health question, please answer "No" to this medication question.

   ☐ Yes ☒ No

Application Number(s) & Product
0062616084 Accident

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

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
0062616084 Accident

FINAL AUTHORIZATION

Proposed Policyowner's Agreement for Accident Coverage

I represent to the best of my knowledge and belief, that all statements and answers on this application form are complete and true. The application form and any amendments shall be the basis for the contract. I also agree that:

The policy, if approved by Time insurance Company, will have the Effective Date recorded on the Policy Schedule by Time Insurance Company. I acknowledge receiving the following, if required:

Fair Credit Reporting Act Pre-Notification
Outline of Coverage (if required by state law)
Abbreviated Notice of insurance Information Practices
Notification regarding the Medical Information Bureau
Guide to Health Insurance for People with Medicare

I understand that the premium amount listed on this application represents the premium amount that my employer will remit on my behalf if I select payroll deduction as the method of premium payment. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me by the agent.

I have read, or had read to me, the completed application and realize that policy issuance is based upon statements and answers provided and any other pertinent information that may be required for proper underwriting. The answers are complete and true to the best of my knowledge and belief. I understand and acknowledge that any fraudulent statement or material misrepresentation on the application and/or any amendments may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provisions in the policy.

Relationship to Primary: Self

Sarah William
(full name)

☒ I Agree
☐ Not Present

Application Number(s) & Product
0062616084 Accident

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: SEW9182@YAHOO.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).

TIME INSURANCE COMPANY

Application Number(s) & Product
0062616085 Accident Medical Expense

Client Summary - Accident Medical Expense

Requested Effective Date: **02/03/2016**

AGENT/AGENCY INFORMATION

Agent Name:	SEAN MCCLOSKEY	Phone Number:	(888) 290-9060
Agent Number:	AA027560-0-00-704	E-mail Address:	HEALTHINSURANCE247@GMAIL.COM
Agency Name:	E BROKER CENTER INC	Agency Number:	AA049407-1-00-401
Fax Number:	(949) 625-0352	**Insurance Company:**	**Time Insurance Company**

PERSONAL INFORMATION

Relationship	Last Name	First Name	Sex	Age	Birthdate	Social Security Number
Primary	William	Sarah	Female	25	12/14/1990	XXX-XX-5305

Resident Address: 3627 HICKER HWY (Street) | Statesville (City) | NC (State) | 28677 (ZIP Code) | Iredell (County)

Phone Number: (704) 380-3248

Email Address: SEW9182@YAHOO.COM

Alternate Phone Number:

Application Number(s) & Product
0062616085 Accident Medical Expense

PAYMENT

Payment Amount: **$12.18**

☒Monthly ☐Quarterly ☐Semi-Annual ☐Annual

Recurring Payment

MasterCard Number: XXXX-XXXX-XXXX-3851
Security Code: XXX
Exp. Date: 06 /2018
Select a desired withdrawal day: 15
Name as it appears on card: Sarah E William
Credit/Debit Card Billing Address:

Mailing Address:	3627 HICKER HWY	Statesville	NC	28677
	(Address)	(City)	(State)	(ZIP Code)

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

AGENT CONTACT INFORMATION

Contact Last Name: MCCLOSKEY
Contact First Name: SEAN
Contact Phone: (888) 290-9060
Contact Fax: (949) 625-0352
Contact Email: HEALTHINSURANCE247@GMAIL.COM

SUBMISSION

Information collected from: Primary - Sarah William

AGENT ATTESTATION

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

ATTENTION: AGENT

SEAN MCCLOSKEY
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.

Application Number(s) & Product
0062616085 Accident Medical Expense

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

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
0062616085 Accident Medical Expense

FINAL AUTHORIZATION

Accident Medical Expense Authorization

- My application, 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 first full premium must be paid. 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 acknowledge receiving the notification regarding the Abbreviated Notice of Insurance Information Practices and the Outline of Coverage (if required) for this plan.
- I acknowledge that I have read the completed application. I attest that all statements and answers on this application are complete, true and correct.

Relationship to Primary: Self

Sarah William
(full name)

☒ I Agree
☐ Not Present

Application Number(s) & Product
0062616085 Accident Medical Expense

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: SEW9182@YAHOO.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).

TIME INSURANCE COMPANY

Application Number(s) & Product
0062616086 Dental

Client Summary - Dental

Requested Effective Date: **02/03/2016**

AGENT/AGENCY INFORMATION

Agent Name:	SEAN MCCLOSKEY	Phone Number:	(888) 290-9060
Agent Number:	AA027560-0-00-704	E-mail Address:	HEALTHINSURANCE247@GMAIL.COM
Agency Name:	E BROKER CENTER INC	Agency Number:	AA049407-1-00-401
Fax Number:	(949) 625-0352	**Insurance Company:**	**Time Insurance Company**

PERSONAL INFORMATION

Relationship	Last Name	First Name	Sex	Age	Birthdate	Social Security Number
Primary	William	Sarah	Female	25	12/14/1990	XXX-XX-5305

Resident Address: 3627 HICKER HWY (Street) | Statesville (City) | NC (State) | 28677 (ZIP Code) | Iredell (County)

Phone Number: (704) 380-3248 Email Address: SEW9182@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

Application Number(s) & Product
0062616086 Dental

PAYMENT

Payment Amount: **$26.50**

☒Monthly ☐Quarterly ☐Semi-Annual ☐Annual

Recurring Payment

MasterCard Number: XXXX-XXXX-XXXX-3851
Security Code: XXX
Exp. Date: 06 /2018
Select a desired withdrawal day: 15
Name as it appears on card: Sarah E William
Credit/Debit Card Billing Address:

Mailing Address:	3627 HICKER HWY	Statesville	NC	28677
	(Address)	(City)	(State)	(ZIP Code)

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

AGENT CONTACT INFORMATION

Contact Last Name: MCCLOSKEY
Contact First Name: SEAN
Contact Phone: (888) 290-9060
Contact Fax: (949) 625-0352
Contact Email: HEALTHINSURANCE247@GMAIL.COM

SUBMISSION

Information collected from: Primary - Sarah William

AGENT ATTESTATION

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

ATTENTION: AGENT

SEAN MCCLOSKEY
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

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
0062616086 Dental

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

Sarah William
(full name)

☒ I Agree
☐ Not Present

Application Number(s) & Product
0062616086 Dental

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: SEW9182@YAHOO.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).

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. This authorization is valid for 30 months from the date the application is signed. You have the right to receive a copy of this authorization.

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, Enrollment 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 appropriate regulatory agency in your state.

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(s) 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.

LEAVE THIS PAGE WITH THE CUSTOMER - DO NOT FAX

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event

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
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

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 health insurance assistance program SHIP.

LEAVE THIS PAGE WITH THE CUSTOMER - DO NOT FAX

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.