**MEDICAL INSURANCE WAIVER**

**PREMIUMS**

**MONTHLY ACTUAL PREMIUMS (FOR MEN)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Age | P1 | P2 | P3 | P4 | P5 | P6 |
| 30 | 9,85 | 19,65 | 29,49 | 39,29 | 58,94 | 78,59 |
| 35 | 10,07 | 20,13 | 30,19 | 40,26 | 60,39 | 80,52 |
| 40 | 10,33 | 20,63 | 30,95 | 41,27 | 61,90 | 82,53 |
| 45 | 10,56 | 21,17 | 31,76 | 42,34 | 63,51 | 84,68 |
| 50 | 10,86 | 21,73 | 32,38 | 43,45 | 65,18 | 86,90 |
| 55 | 12,49 | 24,99 | 37,48 | 49,98 | 74,96 | 99,95 |
| 60 | 14,67 | 29,35 | 44,02 | 58,69 | 88,04 | 117,39 |

This Medical Insurance Waiver (“Waiver”) has been signed this 10th of July, 2040 by **Theodore Scott** (“Patient”), who acknowledges and agrees to the terms provided below[[1]](#footnote-1):

**TERMS AND CONDITIONS**

1. I acknowledge that I have been offered medical insurance by iXonsurance Co., which includes coverage for my eligible dependent(s)[[2]](#footnote-2).
2. I recognize that if I fail to enroll a dependent or provide proof of alternative insurance coverage by the deadline of August 25, 2040, I will be automatically enrolled in single medical coverage. I understand that I will not be able to waive or modify my status until the next open enrollment period.
3. In all circumstances, I agree to indemnify and hold my Insurance Provider harmless from any risks, dangers, injuries, or death that I may experience during my Dental Restoration (“Surgery”).
4. I confirm that I am of legal age, have read and comprehended the contents of this document, and am signing this waiver voluntarily.

**IN WITNESS WHEREOF**, the Patient has executed this Waiver as of the date signed below.

## EXCLUSIONS

**Payments may be suspended if there is a delay in processing documents or if required information is incomplete or inaccurate.**

The insurer is not responsible for processing delays caused by third-party providers or external agencies. Coverage will resume once all required documents are received and verified.

**Insurance Premium Rate Table**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
| **Age** | **P1** | **P2** | **P3** | **P4** | **P5** | **P6** |
| 25 | 8,75 | 17,50 | 26,25 | 35,00 | 52,50 | 70,00 |
| 30 | 9,85 | 19,65 | 29,49 | 39,29 | 58,94 | 78,59 |
| 35 | 10,07 | 20,13 | 30,19 | 40,26 | 60,39 | 80,52 |
| 40 | 10,33 | 20,63 | 30,95 | 41,27 | 61,90 | 82,53 |
| 45 | 10,56 | 21,17 | 31,76 | 42,34 | 63,51 | 84,68 |
| 50 | 10,86 | 21,73 | 32,38 | 43,45 | 65,18 | 86,90 |
| 55 | 12,49 | 24,99 | 37,48 | 49,98 | 74,96 | 99,95 |
| 60 | 14,67 | 29,35 | 44,02 | 58,69 | 88,04 | 117,39 |
| 65 | 17,36 | 34,72 | 52,08 | 69,44 | 104,18 | 138,90 |
| 70 | 20,83 | 41,67 | 62,50 | 83,33 | 125,00 | 166,67 |
| 75 | 25,00 | 50,00 | 75,00 | 100,00 | 150,00 | 200,00 |
| 80 | 26,04 | 52,08 | 78,13 | 104,17 | 156,25 | 208,33 |

1. The Waiver becomes effective upon the patient’s signature and submission. [↑](#footnote-ref-1)
2. Dependent coverage includes spouse and up to two children under 18. [↑](#footnote-ref-2)