You must read the following script verbatim. Information inside the [highlighted brackets] represents options. You must fill in the blank based on the options the customer has selected during the enrollment process. Information within the **(parentheses)** is instructions for you and *should not* be read aloud to the customer.

Mr./Mrs./Ms. _____. My name is [your name]; this conversation will be recorded for compliance purposes, and will also serve as a permanent verification record of your application. You were transferred to me to verify the information that you provided to your licensed agent, [state agents first and last name], regarding your application for the Affiliated Workers Association ("AWA") Precise Choice STM Membership which includes short term medical insurance underwritten by: *(read insurance company that pertains to prospect's state of residence.)*

- **National Health Insurance Company (NHIC)** in – AL, AZ, AR, DC, GA, ID, IL, IN, KY, LA, MI, MS, NE, NV, NC, ND, OH, OK. PA, SC, TN, TX, VA, WV, WI, WY.
- **Integon Indemnity Corporation (IIC)** in – FL.

If you have any questions about the coverage or benefits, I will transfer you back to your agent. *(If the verifier is not licensed, he/she should tell the customer.)*

1. Today is [today's date] and the time is: _____.
2. Please state your full name and mailing address for the verification. **(Wait for response)**
3. Please state your date of birth and last four digits of your social security number for the verification. **(Wait for response)**
4. Please state your email address for the verification. **(Wait for response)**
5. Please confirm that you are also enrolling the following dependents on your membership application: **(Verify each dependent's name and date of birth, starting with the spouse, and then each child. Verify that each child is under the age of 26 and unmarried)**
6. Are you currently on Medicare, Medicaid, Medical Disability or any other Federal or state funded program? **Yes/No**

Please answer the following Health Eligibility questions completely and accurately in Yes or No answers. [SI STM plans ONLY]

A. Are you or any applicant:
   i. Now pregnant, an expectant father, in process of adoption, or undergoing infertility treatment?
   ii. Over 300 pounds if male or over 250 pounds if female?

B. Within the last 5 years has any applicant been diagnosed, treated, or taken medication for or experienced signs or symptoms of any of the following: cancer or tumor, stroke, heart disease including heart attack, chest pain or had heart surgery, COPD (chronic obstructive pulmonary disease) or emphysema, Crohn's disease, liver disorder, degenerative disc disease or herniation/bulge, rheumatoid arthritis, kidney disorder, diabetes, degenerative joint disease of the knee, alcohol abuse or chemical dependency, or any neurological disorder?

C. Within the last 5 years has any applicant been diagnosed or treated by a physician or medical practitioner for Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV)?

D. Have you been hospitalized for mental illness in the last 5 years or have you seen a psychiatrist more than 5 times during the last 12 months?

- **Indiana Residents Only:** Will any applicant have other health insurance in force on the policy effective date or be eligible for Medicaid?
- **Tennessee Residents Only:** Have you or any applicant been denied insurance due to any health reasons for a condition that is still present?

E. If you are not a U.S. Citizen, do you expect to legally reside in the U.S. for the duration of the STM policy term?

IF ANY APPLICANT(S) ANSWERED "YES" TO QUESTIONS A THROUGH D OR "NO" TO QUESTION E ABOVE (INCLUDING IN & TN QUESTIONS), THEY DO NOT QUALIFY FOR THE SIMPLIFIED ISSUE SHORT TERM MEDICAL INSURANCE AND IT CANNOT BE ISSUED. PLEASE PRESENT THE GUARANTEED ISSUE STM PLAN AT THIS TIME.

Residents in the following states need to answer the questions below for all family members applying for coverage. [SI & GI STM plans]

- **Idaho residents:** Have you or any person to be insured had prior Short Term Medical coverage with Us[1] within the last 64 days? (You must wait at least 64 days between plans.)
- **Michigan & Nevada residents:** In the last 12 months, have you or any person applying for coverage been insured with a Short Term Medical plan with Us[1] for 185 days (6 months)?
- **North Dakota residents:** Have you or any person applying for coverage, had more than one Short Term Medical plan(s) with Us[1]? (You must wait at least 11 months between plans.)
- **Tennessee residents:** Have you or any person applying for coverage been covered under a Short Term Medical plan in the last 30 days? (You must wait at least 30 days between plans.)

[1] "Us": National General Accident & Health markets products underwritten by National Health Insurance Company, Time Insurance Company, Integon National Insurance Company, and Integon Indemnity Corporation.

IF APPLICANT(S) ANSWERED "YES" TO ANY QUESTION ABOVE, INDIVIDUALS WILL NOT BE ABLE TO ENROLL IN AN AWA MEMBERSHIP THAT INCLUDES SHORT TERM MEDICAL INSURANCE.

Thank you. Next I am going to ask you to confirm several statements about the Precise Choice membership you are enrolling in. After each statement, I will ask you to confirm by saying, "I agree". Do you understand? **(Wait for response)**

7. You have selected the following coverage options for the Short Term Medical plan included in your AWA Precise Choice membership:
   - Your deductible is [$1000, $2500 or $5000 with an 80/20% coinsurance] [$10,000 with a 100/0% coinsurance]. Please confirm. **(Wait for response)**
   - Your policy term length will be [1 month, 2 months or 3 months less one day]. Please confirm. **(Wait for response)**
8. You understand that the plan is subject to out of pocket expenses, including your deductible and then coinsurance, once the deductible has been met.

   (If applying for family coverage, read the following):
   The maximum deductible for the family coverage is 3 times the individual deductible. Once three of the individual deductibles have been met any additional individual deductibles will be deemed satisfied.

   The plan will pay [(SI) 80%, 100% / (GI) 80%, 90%] of the charges after your deductible has been met, not to exceed the maximum amount of Covered Expenses for each benefit. You will pay [(SI) 20%, 0% / (GI) 20%, 10%] of these charges, plus any excess charge beyond the usual and customary or beyond the maximum amount of Covered Expenses for each benefit. Please confirm. **(Wait for response)**

   You understand that your plan has a maximum coinsurance limit of **(choose the "out of pocket maximum" amount from the chart below according to the plan that was chosen.)**

Standard Issue (SI) Plan Options

Deductible	$1,000	$2,500	$5,000	$10,000
Coinsurance	80/20%	80/20%	80/20%	100/0%
Out-of-Pocket Maximum (in addition to Deductible)	$1,500	$1,500	$2,500	$0

Guaranteed Issue (GI) Plan Options

Deductible	$3,500	$5,000
Coinsurance	80/20%	90/10%
Out-of-Pocket Maximum (in addition to Deductible)	$6,500	$5,000

7. You understand that after the deductible and coinsurance limits have been met, then the insurance company pays 100% of the Usual and Customary Expenses, not to exceed the limits of any Covered Benefits as defined by the contract, up to the Lifetime Maximum of [(SI) $1,000,000 / (GI) $100,000] payable for each Covered Person. **Yes/No**
8. You understand that doctor's office visits are subject to the deductible and coinsurance. **Yes/No**
9. You understand that the Short Term Medical Insurance included in the AWA Precise Choice STM membership is NOT considered "Minimum Essential Coverage" under the Affordable Care Act and therefore, you may be subject to a tax penalty? You also understand that this is not designated as a substitute for comprehensive major medical coverage. **Yes/No**
10. You understand that the Short Term Medical Insurance included in the AWA Precise Choice STM membership will not pay benefits for services provided by any state or federal government agency, including the Veteran's Administration unless by law, you must pay for such services? **Yes/No**
11. You understand that your AWA Precise Choice STM membership provides you with access to the Aetna Open Choice® PPO Network's, pre-negotiated reduced rates and it is your responsibility to locate and use an in-network provider to receive the reduced rates? **Yes/No**
12. You understand that your insurance certificate will be available online, and it is your responsibility to review the information to fully understand your benefits and to be sure they are consistent with your understanding of the plan you have purchased. If there is any difference between what you understand of how the policy works based on your discussion with your agent, the terms of the policy certificate will govern? **Yes/No** (If the member does not have computer access, inform them we will request to have their insurance certificate mailed to them.)
13. You agree that the short term medical insurance included in the AWA Precise Choice STM membership will not become effective for any person whose medical history changes prior to insurance approval, such that the person's answer would be "yes" to any of the Medical History questions in this application. If such person is the Applicant, insurance is automatically declined for all persons included in this application. **Yes/No**
14. You understand that pre-existing conditions are NOT covered on the Short Term Medical Insurance included in the AWA Precise Choice STM membership. A pre-existing condition is any condition or symptom for which medical advice, diagnosis, care or treatment was recommended or received prior to the effective date of coverage. You further understand that National Health Insurance Company will look back at the past 12 months of your medical history to determine if any diagnosis or medical services would be considered a pre-existing condition. (Pre-existing conditions limitation does not apply in IL) **Yes/No**
15. You will have 10 days from your effective date to review the Short Term Medical Insurance benefits included in your AWA Precise Choice membership. This period is referred to as a "free look" period and means that if within those 10 days, you change your mind about the purchase, you can cancel for a full refund (including enrollment fee), provided you furnish written notification to Member Services within the "free look" period. Memberships returned within the free look period will be terminated back to the effective date and you will forfeit any potential claims in lieu of your refund. Any cancellation requests received after the free look period are subject to a 10-day minimum cancellation notice, and the cancellation will become effective at the end of the month, no earlier than 10 days after receipt of the written cancellation request. There are no prorated fees or rebates after the first 10 days. Do you understand and agree? **Yes/No**

FRAUD STATEMENT (Read the fraud statement to applicants based on their resident state. State specific fraud statements are listed for the following states: AL, AR, DC, FL, KY, LA, OH, OK, PA, TN, TX, VA. Read the "All other states" fraud statement if the state-specific statement is not available in their state.)

[All other states] Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud as determined by a court of law.

[Alabama] Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

[Arkansas & West Virginia] Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application is guilty of a crime and may be subject to fines and confinement in prison.

[District of Columbia] It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

[Florida] Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

[Kentucky] WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

[Louisiana] Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

[Ohio] Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.

[Oklahoma] WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claims for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

[Pennsylvania] Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

[Tennessee] It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

[Texas] Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application/enrollment form containing any false, incomplete, or misleading information may be guilty of a crime and may be subject to fines and confinement in prison.

[Virginia] Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Association Benefits

You understand that your AWA Precise Choice STM membership also includes many health and wellness benefits such as Teladoc Telemedicine, Karis360 Patient Advocacy Services, and many other health care, consumer/lifestyle and business benefits? **Yes/No**

Do Not read the DMPO disclaimer below to residents of Florida and Oklahoma:

The Discount Medical Plans are provided by Alliance Health Card of Florida, a discount medical plan organization. The features are not health insurance policies and are not available in all areas. The features provide discounts at certain health care providers for medical services and do not make payments directly to the providers of medical services. The member is obligated to pay for all health care services but will receive a discount from those health care providers who have contracted with Alliance Health Card of Florida, Inc. P.O. Box 630858, Irving, TX 75063.

16. If you submit a claim under any of the insurance benefits included with your membership(s), you will be deemed to have accepted the membership and you will not be eligible for any refund. All cancellations must be directed to Member Services at (855) 351-7536. Do you understand and agree? **Yes/No**

17. You understand that the broker who solicited this application was acting as an independent contractor and not as an agent of the Insurance Company. You further acknowledge that the person who solicited this application and upon whose explanation of benefits, limitations or exclusions we relied, was retained by you as your agent, and that such person has no right to bind or approve insurance or alter any of the terms or conditions of the policy. You do understand? **Yes/No**

18. You understand that any material misstatement or omission of information made on this call will be considered a misrepresentation and may be the basis for later rescission of your insurance and that of your dependents. In the event of rescission, the Insurer shall have the right to deduct any paid claims from the premium that would otherwise be returned to you. In the event of termination for any reason, the Insurer shall have the right to deduct any unpaid premiums from any claims payable to you or your dependents. You do understand? **Yes/No**

19. You acknowledge that I have read this application to you and that you have verified that all of the information provided herein is complete, true and correct, and is all within your personal knowledge. You agree to immediately notify the insurer of any changes in any of the information contained in this form which may occur prior to the approval of this insurance. You do understand? **Yes/No**

20. You agree that your effective date is [effective date]? **Yes/No**

21. Your initial payment today is $_____, which includes:

    $_____ for the AWA Precise Choice STM plan (STM Rate + DMPO Benefits + VAB Plus + Monthly Admin fee)

    $_____ for the Affiliated Workers Association one-time enrollment processing fee

    Your regular monthly payment will be $_____, and will be automatically charged or drafted on the ____ of every month from your credit card/debit card/bank account provided to us today. You do understand? **Yes/No**

22. You are the holder of the credit card/debit card or bank account? **Yes/No**

    If [No]: Please place the account holder on the phone to verify the account information.
    Or
    If [No]: Please have the account holder call us back with the account information to complete the verification process.
    If [Yes]: Continue the conversation.

23. If [credit/debit card]: The card you provided to me was a [Visa, MC, Discover, AMEX] and that card number is _____, expiration is _____ and the CVV code is _____. **Yes/No**
    Or
    If [ACH]: The routing number you provided is _____ and the account _____. **Yes/No**

24. We have your permission to debit your credit card/debit card or draft your bank account today (today's date) for your initial payment of $_____? **Yes/No**

You will receive an email within the next 24 hours containing your ID number and Member Portal link. You'll use your username and password from your account creation email to log in to your account. When you log in to the web portal, you will have access to your benefits guide, as well as provider links and other membership information. You can review, print and download all of your important documents.

PLEASE LOGIN TO THE MEMBER PORTAL AND E-SIGN THE AUTHORIZATION FORM TO CONFIRM YOUR ENROLLMENT. You will also receive two separate welcome letters in the mail – one will contain your official AWA ID card(s) and the other will contain your insurance ID card(s) as well as online access instructions for obtaining your insurance certificate, normally within 7-10 business days. If you do not have access to a computer, please let me know and I will request that your certificate be mailed to you.

By enrolling in this AWA Membership Plan you are agreeing to receive your membership materials (including instruction guides) via email in addition to important notifications regarding your membership. If you have any questions or need any assistance, please call (800) 269-3563.

Please Note: Premier Health Solutions, LLC is the administrator of all AWA membership plans and products. Premier Health Solutions, LLC markets and sells under the name PHSI Insurance Agency, LLC in California and under the name PremierHS, LLC in Kentucky, Ohio, Pennsylvania, South Carolina and Utah.

This will conclude the verification. Thank you for your time and welcome to the Affiliated Workers Association.