PivotCARE Limited Benefit Health Insurance Verification Script

Underwritten by Standard Life & Accident Insurance Company

- **Agent - Please enter your Pivot Health Producer Number followed by the # key. (see number on your URL Link or Appointment)**
- **Application completed over the phone.**

1. Hello, this is an automated attendant from Pivot Health. The reason for this call is to confirm your selection of benefits for the Limited Medical plan and ensure everything was recorded correctly. This call is being recorded for quality assurance. You must complete the acknowledgements we will be requesting to further process your application. The process will only take a couple of minutes more of your time.

2. Please state your name _____
   You stated your name as [system plays recorded name], is that correct?

3. Please state your (full address).____

4. You stated your address as [system plays recorded address], is that correct?

5. Today is _____ (today's date) and the time is: _____.

6. Your initial payment today is $_____, which represents your first month's membership dues plus a onetime membership processing fee of $____, thereafter, your monthly dues will be $_____ which will be automatically charged or drafted on the ____ of every month from your credit card/debit card/bank provided to us today, do you agree? Yes/No (**Please Note:** A1 Healthcare provides the benefits administration and management services for PivotHealth. As such, you will see "**A1 Healthcare 800-319-7061" if paid by credit card or "Health 8003197061" if paid by ACH**.)

7. 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 and 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 with the verification process.

8. If you are not satisfied with your membership, you may cancel **within 30 days from your effective date** and receive a full refund on your monthly membership dues. You agree to review the terms and conditions of your plan during its 30 day free look period. All cancellations must be directed to Member Services at (800) 269-3563. Do you understand and agree? **Yes/No**

9. You do agree that are enrolling in the PivotCARE Limited Benefit plan level_____? **Yes/No**

   ***NOTE: The Critical Illness Benefit is not available in VA. The Critical Illness Benefit is available as an optional add-on in Georgia.**

   The PivotCARE Limited Benefit plan level you have selected includes the following:
   (READ THE BENEFITS APPLICABLE TO THE PLAN LEVEL CHOSEN)

   To confirm your understanding of these statements, pleas answer Yes or No.

10. **VOICE CONSENT** We want to confirm that you agreed to the completion of your application for the Limited Benefit Plan over the telephone, and that the plan benefits, legal notices and cost of the insurance were reviewed with you. You agree that your voice consent will serve as your signature and you understand that Standard Life and Accident Insurance Company will rely on your signature unless you revoke this consent. You can update your information or revoke this consent at any time by calling PivotHealth at **(866)566-2707**. **Yes/No**

We want to make certain you understand the benefits provided by this coverage and we feel it is important to assure that you have a clear understanding of exactly what is covered by this policy. This coverage is indemnity coverage. That means it does not pay a set percentage of medical bills, rather this coverage pays a set dollar amount. The dollar amounts are elected by you and the benefits will usually be lower than the actual charges. You will be responsible for any additional amounts owed to the providers who rendered medical care to you. **Yes/No**

It is important for you to review the policy when you receive it to fully understand the benefits, terms, exclusions, and limitations You will have 30 days to review your policy s and if you are not completely satisfied you can return it for a full refund.

11. **Some important policy provisions you need to be aware or are:**
    - No benefits are payable for sickness during the first 30 days following the Policy Effective Date.
      NOTE: For **Montana** residents, there is no waiting period.

    - Pre-existing conditions are excluded for 12 months.
      NOTE: For residents of **Pennsylvania, Nevada, or Wyoming** the pre-existing period is 6 months.

      Do you understand and agree?

      - **Yes/No**

12. **Now I am going to read the questions from the evidence of insurability to confirm that everything was recorded correctly.**
    - No Applicant or any Proposed Insured is unemployed (does not include homemaker, students, or children) or engaged in any of the following occupations: Active Military/Asbestos workers/Nuclear Energy Workers/Crop-dusters/Explosives/Hazardous Chemical Exposure or Toxic Waste workers/Offshore oil well drilling or operations workers/Professional athletes/Quarry workers or underground miners/Stunt or acrobatic flying?
      - **Yes or No**
    - No Applicant or any Proposed Insured has been hospitalized or received disability benefits in the last six months?
      - **Yes or No**

    - No Applicant or any Proposed Insured currently pregnant, an expectant parent, or in the process of adopting a child?
      - **Yes or No**

    - No Applicant or any Proposed Insured participated in skydiving, hang gliding, parachuting, bungee jumping, rock, or mountain climbing, scuba diving at depths over 200 FT, motorcycle racing or any type of racing, professional sports, piloting an aircraft as an instructor, student or crop duster, or rodeo events?
      - **Yes or No.**

- In the past 2 years, no Applicant or ant Proposed Insured had a driver's license suspended, had 3 or more traffic violations, DWI/DUI/OUI's or been arrested?
    - **Yes or No.**

- In the past 2 years, no Applicant or any Proposed Insured been advised to have any diagnostic/screening test or procedures which have not yet been performed?
    - **Yes or No**

- Within the past 5 years, has the Applicant or any Proposed Insured had not had a result, received treatment, taken prescription medication for, or been recommended to have treatment for any of the following conditions:
    - Acquired Immune Deficiency Syndrome (AIDS)/ AIDS Related Complex (ARC)/ Human Immunodeficiency Virus (HIV)
    - Hepatitis B or C / Lupus Erythematosus
    - Melanoma Cancer/ Internal Cancer (does not include skin cancer)
    - Alcohol or Drug Abuse/ Substance Abuse
    - Arterial Disease/Heart Disease or Heart Surgery/Heart Attack/ Heart Surgery/ Peripheral Vascular Disease
    - Bipolar Disorder/ Manic Depression/ Major Depression
    - Insulin Dependent -Diabetes (Does Not include Type II Diabetics)
    - Cerebrovascular Accident (CVA)/Stroke/ Transient Ischemic Attack (TIA)
    - Chronic Obstructive Pulmonary Disease (COPD)/ Emphysema/Lung Disease
    - Osteoporosis with History of Bone Fracture/ Rheumatoid Arthritis
    - Cirrhosis/Liver Disease/Kidney Disease/ Organ Failure/ Organ Transplant
    - Crohn's Disease (Ileitis)/ Ulcerative Colitis
    - Multiple Sclerosis/ Fibromyalgia/ Paralysis (any type or degree)/ Muscular Dystrophy/ Myositis/Lou Gehrig's Disease (ALS)
    - Organic Brain Syndrome/Dementia/ Alzheimer's Disease
        - **Yes or No.**

13. You understand that the coverage applied for provides limited benefits and is not a major medical or comprehensive medical benefit plan and is not a substitute for such coverage. The Policy is limited and is not designed to cover all medical expenses. You understand that this coverage does not meet the minimum standards required by The Federal Health Care Reform Law. Therefore, if you do not purchase or have comprehensive medical insurance, or unless you are exempt from the tax for some other reason, you maybe subject to a tax penalty. Do you understand these terms and conditions? **Yes/No**

DECLARATION AND AGREEMENT: It is declared that all statements and answers in this application are complete and true to the best of your knowledge and belief. You understand that this information will be used to determine each person's eligibility for coverage under the Policy and any false statement or misrepresentation may result in loss of coverage or claim denial. You (and your Spouse or Dependent, if applying) must be eligible based on the Company's rules in effect on the date of Application and on the Policy Effective Date. Policy coverage (or Reinstatement of coverage), if approved and issued by the Company, will become effective on the date recorded in the Policy Schedule of Benefits and not the date the application is signed. You understand that no agent or producer can accept risks, modify policies, or waive any rights or requirements of the Company.

Any person presenting a false or fraudulent claim for payment of a loss or benefit, or knowingly presenting false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

14. You will receive an email within the next 24 hours that will include a link to the member portal. 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'll be able to review, print and download all your important documents. If you have any questions or need any assistance, please call Member Services at **(800) 269-3563).** By enrolling in this plan, you are agreeing to receive your membership materials (including instruction guides and ID cards) via email in addition to important notifications regarding your membership.

That completes your verification. Please do not hang up as your agent needs to complete the finalization of your application. Agent, please insert the following code on the application in the verification call box xxxxxx. That number again is xxxxxx. Again, thank you for your time, and have a wonderful day!