

**AMERICAN HEALTH SOLUTIONS SERIES  
ASSOCIATION GROUP CATASTROPHIC HOSPITAL INSURANCE  
FOR MEMBERS OF THE  
NATIONAL CONSUMER'S ADVANTAGE ASSOCIATION  
AND THEIR FAMILIES**



**Individually Underwritten  
Association Group Catastrophic Hospital Insurance  
Underwritten By Standard Life and Accident Insurance Company  
Administrative Offices, Galveston, Texas**



The American Health Solutions Series Association Group Catastrophic Hospital Insurance plans are underwritten by **Standard Life and Accident Insurance Company** a member of the American National family of companies. Administrative Offices in Galveston, TX.

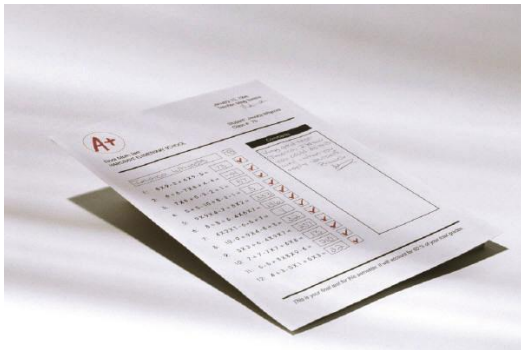
Standard Life and Accident Insurance Company (“Standard Life”) has been evaluated and assigned the following ratings by nationally recognized, independent rating agencies. The ratings are current as of January 2006.

**A.M. Best**                      **A** (Excellent)                      3<sup>rd</sup> highest of 13 active company ratings <sup>1</sup>

**Standard & Poor’s**            **AA-** (Very Strong)                      4<sup>th</sup> highest of 20 active company ratings <sup>2</sup>

Ratings reflect current independent opinions of the financial capacity of an insurance organization to meet the obligations of its insurance policies and contracts in accordance with their terms. They are based on comprehensive quantitative and qualitative evaluations of the company and its management strategy. The rating agencies do not provide ratings as a recommendation to purchase insurance or annuities. The ratings are **not a warranty** of an insurer’s current or future ability to meet its contractual obligations.

Ratings may be changed, suspended, or withdrawn at any time. For the most current ratings visit Standard Life’s Internet site at [www.slaico.com](http://www.slaico.com).



<sup>1</sup> A.M. Best’s active company rating scale is: A++ (Superior), A+ (Superior), A (Excellent), A- (Excellent), B++ (Very Good), B+ (Very Good), B (Adequate), B- (Adequate), C++ (Fair), C+ (Fair), C (Marginal), C- (Marginal) and D (Poor).

<sup>2</sup> Standard & Poor’s active company rating scale is: AAA (Extremely Strong), AA (Very Strong), A (Strong), BBB (Good), BB (Marginal), B (Weak), CCC (Very Weak) and CC (Extremely Weak). Plus (+) or Minus (-) modifiers show the relative standing within the categories from AA to CCC.

**These ratings are provided to you so that you may make a comparison of Standard Life and Accident Insurance Company to other companies. They are not provided as a recommendation by the rating companies to purchase this coverage.**

**Notice-The association group insurance policy described in this brochure is available only to members of the National Consumer’s Advantage Association and is not intended to be an employer sponsored health insurance plan.**

**NCAA members enjoy a number of health, travel, consumer and business related benefits for a nominal monthly membership fee.**

National Consumer's Advantage Association (NCAA) was formed in 1993 to educate and benefit members by providing information, resources and access to savings on products and services. Association membership rates are subject to change without notice. NCAA offers two levels of membership to fit the needs of prospective members.

**SILVER** level membership dues are \$2.50 per month and provides a basic benefit package.

#### **Silver Membership Benefits**

- Med Script Discount Pharmacy Service-Managed Care mail order service providing up to 50% savings on prescriptions.
- Lens Crafters Vision Club-20% discount on purchases; 10% discount on eye exams and contact lenses at some stores.
- Hearing Services-Up to 60% discount on quality hearing aids.
- Vitamin and Nutrition Supplement Discounts- discounts on a wide range of products.
- Car Rental Discounts-Special savings at Alamo, Avis, Hertz or National.
- North American Van Lines Moving Discounts-Substantial discounts on relocation services.
- Penny Wise Office Supply Discounts-Up to 36% off already discounted prices on a large selection of items.
- Powernet Global-Long distance rate of 5.4 cents per minute state-to-state, 24 hours a day, 7 days a week.
- Customized Web Sites-20% discount on full-service web site development and maintenance.
- Internet Access Services-Discounts on unlimited dial-up access to the Internet.
- Gateway Emergency Medical Card-Wallet-size card provides personal medical profile in case of emergencies.

**GOLD** level membership dues are \$4.50 per month and provides Silver Membership benefits plus access to additional privileges and services.

#### **Gold Membership Benefits**

*In addition to all Silver Membership Benefits, Gold Membership Benefits Include:*

- Crisp Learning.
- Office Equipment Financing.
- File Solutions.
- Pre-Employment Background Reports.
- Payroll Processing Services.
- Quest Travel Plan.
- Association Travel Club.
- Emergency Roadside and Travel Assistance.
- Theme Park and Floral service Discounts.
- Magazine Subscription and Movie Ticket Discount.
- AD&D Coverage.
- HopTheShop.com-Cybermall featuring over 150 high quality e-tailers and stores with special discounts and features.
- Dental Discount Plan-Discounts on dental care expenses through more than 24,000 providers. No claim forms, maximums or deductibles.
- Chiropractic Discounts-Up to 40% savings on usual and customary fees.
- Medical Air Transport Services

**Membership Service Office: 16476 Chesterfield Airport Road, Chesterfield, MO 63017  
Phone: 1-800-992-8044 email @egroupmanager.com**

# National Consumer's Advantage Association

Our NCAA members are armed with valuable consumer insight, health news and travel savings tips. Each member receives Car Rental Discount Coupons, Vision Care Discounts, Travel Club Benefits and various other consumer and discount materials.

To purchase the Health Insurance plan identified in the enclosed application, you must first be a member of National Consumer's Advantage Association. If you have questions regarding your membership, please call the Association at 1-800-992-8044.



**Yes, I want to be a member of NCAA!**

*Please Choose One:*

**Silver Level (\$2.50 per month or \$30 annually)**

**Gold Level (\$4.50 per month or \$54 annually)**

## NCAA

National Consumer's Advantage Association  
16467 Chesterfield Airport Road, Chesterfield, MO 63017

Under Bylaws of the Association now or as amended, with resulting cost savings that ultimately benefit me as a member, by delivery of this signed enrollment form to National Consumer's Advantage Association, I appoint its President as my proxy irrevocably to vote and otherwise act. This proxy shall be of no effect at any meeting that I personally attend.

Signed

Print Name

Phone

Date

Address

City, State, Zip

Dues will be included in your regular premium notices or drafted from your account, if you elect the automatic bank draft option.

**Plan Design:**

Indemnity or Preferred Provider Option

**Issue Ages:**

0-63 ½

**Maximum Lifetime Benefit Per Covered Person:**

\$5,000,000

\$1,000,000 for each Injury or Sickness

**Coinsurance Options:**

100%, 80% or 50%

**Stop-Loss Amounts:**

\$5,000 or \$10,000 (With coinsurance options 80% or 50%)

**Calendar Year Cash Deductibles:**

\$750; \$1,500; \$2,000; \$2,500; \$5,000; \$10,000 or \$15,000

**Special Deductible Features:**

- No more than 3 Cash Deductible Amounts per family per Calendar Year
- Only one Cash Deductible Amount must be met when one or more Covered Persons are injured in the same accident.
- A Vanishing Deductible feature allows a family member's Calendar Year Cash Deductible Amount to decrease by 25% per year following each **consecutive complete Calendar Year** in which no benefits were paid on behalf of all Covered Persons named on the Certificate. The full deductible is reinstated following the Calendar Year in which benefits are paid. This special feature applies only to the Cash Deductible Amount under the base plan. We will not give any further reductions once the Cash Deductible Amount is reduced to zero.

**This Association Group Catastrophic Health Insurance is designed to provide benefits for high cost hospital confinements. Coverage for additional outpatient services can be obtained by adding riders, available for additional premium, to your base plan.**

This brochure contains a brief description of the coverage under the Group Policy Form SLA-P06. Coverage may vary depending upon Your state of residence. Consult Your agent for specific exceptions or changes. The Group Policy is the contract of insurance. Your Certificate describes in greater detail the rights and obligations of both You and the insurance company under the Group Policy. It is, therefore, important that You read Your Certificate carefully. A sample is available, please ask Your agent.

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### **Covers a Wide Range of Care:**

- Hospitals
- Same Day Surgery Facility
- Home Health Care
- In-Hospital Doctor Visits
- Surgery
- Assistant Surgeon
- Organ Transplants
- Blood, Blood Plasma and Derivatives
- Anesthesia
- Hospice
- Mammograms
- Second Surgical Opinion
- Ambulance



### **Other Plan Features:**

- You cannot be singled out for rate increase
- You cannot be singled out for cancellation
- 24 hour coverage-7 days a week
- No pre-admission certification required

### **Restoration of Benefits:**

Each January 1<sup>st</sup>, We will restore the lesser of (a) the used portion of the Maximum Lifetime Benefit or (b) \$100,000.

### **Human Organ Transplant:**

The Maximum Lifetime Benefit for all Organ Transplants combined is \$1,000,000 per Covered Person. When performed at a Transplant Center the Maximum Benefit will be up to the Group Policy Lifetime Maximum Benefit. If you select the Preferred Provider Option and the transplant is performed out-of-network the Maximum Benefit will be the lesser of the lowest negotiated rate or \$1,000,000.

### **Optional benefit riders for added protection: (for additional premium)**

Outpatient Accident Expense Benefit Rider

Outpatient Doctor Rider

Outpatient Prescription Drug Rider

Post Confinement Therapy Rider

This brochure contains a brief description of the coverage under the Group Policy Form SLA-P06. Coverage may vary depending upon Your state of residence. Consult Your agent for specific exceptions or changes. The Group Policy is the contract of insurance. Your Certificate describes in greater detail the rights and obligations of both You and the insurance company under the Group Policy. It is, therefore, important that You read Your Certificate carefully. A sample is available, please ask Your agent.

**Note: This coverage does not provide benefits for the treatment of alcoholism.**

**After You have met Your Cash Deductible and Your selected coinsurance is less than 100%, the plan pays either 50% or 80% up to Your selected Stop Loss Amount. Once you have met this limit the plan pays 100% of the additional Eligible Expenses during the remainder of the Calendar Year.**

**Eligible Expenses While Hospital Confined or at a Same Day Surgical Facility including the Reasonable and Customary Charges for:**

- Daily average semi-private hospital room & board
- Hospital charges for **Intensive Care, Cardiac Care or Neonatal Intensive Care Unit**
- Miscellaneous In-hospital Expenses including operating room, recovery room, anesthesia, central supplies, x-rays, Lab, oxygen, medicines or drugs, splints or casts
- In-hospital Doctor visits for one visit per day
- Blood, blood plasma or blood derivatives
- Surgeon's fees
- Physiotherapy for physical therapy , speech therapy, or inhalation therapy
- Pathology and Radiology

**Eligible Expenses for services provided outside a Hospital or Ambulatory Surgical Facility**

- Reasonable and Customary charges for professional ambulance services (ground or air) to the nearest hospital qualified to treat the injuries or medical emergencies
- Home Health Care up to 60 visits per Calendar Year at \$40 per visit
- Reasonable and Customary charges for Hospice Care per Covered Person

#### **SLACATPP0 Preferred Provider Rider**

This rider reduces the cost of the base coverage. Cost of other optional riders is not affected by the addition of this Rider.

When You or a Covered Person is admitted to a Preferred Provided Hospital or Same Day Surgery Facility and receive treatment from Preferred Provider Doctors in such facilities; any resulting benefits payable under the Group Policy will be payable at the selected Coinsurance Percentage.

When You or a Covered Person is admitted to a Hospital that is not a Preferred Provider Hospital; use a Same Day Surgery Facility that is not part of Preferred Provider Same Day Surgery Facility; or receive treatment from a Doctor who is not a Preferred Provider Doctor; any benefits payable under the Group Policy will be payable at a coinsurance rate that is 20% less than the selected Coinsurance Percentage, unless such admission, use or treatment is the result of an Emergency.

#### **Optional Additional Benefit Riders: (for additional premium)**

**SLACATAC Accident Expense Rider-**If You or a Covered person is injured in an accident and treatment by a Doctor begins within 48 hours, We will pay the Reasonable and Customary Charges incurred for the Medically Necessary Outpatient Treatment of the Injury. Any treatment beyond the initial treatment must be received within 30 days of the Injury. THERE IS NO DEDUCTIBLE. Outpatient means not hospital Confined.

Your choice of benefits is \$400; \$800 or \$1,200 Maximum Benefit for each Covered Person for each accident.

**SLACATPCT Post Confinement Therapy Rider-** This benefit pays up to \$1,200 or \$2,400 per day to a maximum of \$200,000 for Outpatient Hospital Expenses for Radiation therapy, including treatment planning; Chemotherapy, including treatment planning, Physical therapy; Speech and Occupational Therapy. Benefits are payable in connection with treatment of a condition which required a Hospital stay for which benefits were payable under the Group Policy. Benefits payable under this rider are subject to the Group Policy's Cash Deductible Amount and Coinsurance Amount.

**SLACATDR Outpatient Doctor Rider**-After the Calendar Year Cash Deductible Amount of \$1,000 has been met this rider will pay 80% of the Reasonable and Customary Charges up to \$10,000 per Covered Person per Calendar Year for Eligible Expenses incurred on an Outpatient basis. Eligible Expenses include:

- Outpatient Doctor Charges;
- Hospital Emergency room or other Outpatient clinic charges;
- Outpatient Diagnostic tests;
- Administration of anesthesia to a Covered Person undergoing surgery in a Doctor’s office, clinic, Hospital Emergency room or Urgent Care facility;
- Miscellaneous supplies including casts, splints and braces, hypodermics and crutches;
- Prescription drugs taken or administered within 30 days of a Hospital Stay for treatment of the condition for which You were hospital Confined; or
- Childhood immunizations provided on an Outpatient basis, for children under the age of six and are not subject to the Rider’s Cash Deductible Amount.

**SLACATRX Outpatient Prescription Drug Rider** -When selected, this Rider adds an outpatient Prescription Drug benefit to the Group Policy. After You meet the Prescription Drug Calendar Year Deductible Amount and Copayment, We pay the remaining Prescription Drug Eligible Expenses at the selected coinsurance. We do not cover Outpatient Prescription Drugs unless the optional Outpatient Drug Rider is in effect.

When You obtain Prescriptions Drugs from a Non-Participating Pharmacy, You must pay the entire cost of the drugs to the Non-Participating Pharmacy at the time of purchase. You may then send a claim to Standard life for reimbursement. Standard Life will deduct the applicable Copayment and applicable Coinsurance Amount from the total charges and then pay the claim at the negotiated rate it has with a Participating Pharmacy provider.

We consider a Prescription Drug Charge as an Eligible Expense when:

- A Doctor prescribes the drug for treatment of Injury or Sickness;
- The Group Policy does not exclude the Injury or Sickness for which the Doctor has prescribed the drug;
- The Outpatient Prescription Drug Rider does not exclude the drug; and
- A Pharmacy, which is not part of a Hospital or Ambulatory Surgical Center, dispenses the prescription Drug.

We do not cover drugs that are associated with an Injury or Sickness that We have excluded by name or description. We will not pay benefits under this Rider for drugs excluded by this rider.

**Payment for a Prescription Drug does not mean We have any liability under Eligible Expenses. Prescription by a Doctor does not automatically make treatment Medically Necessary.**

**Participating Pharmacy:**

Prescription Drug Calendar Year Deductible:

Individual: \$500 or \$1,000

Family: \$1,000 or \$2,000

Copay:

Generic: \$10, Mail Order Generic: \$30

Brand Name: \$25, Mail Order Brand Name: \$75

**Non-Participating Pharmacy:**

Prescription Drug Calendar Year Deductible:

Individual: \$1,000 or \$2,000

Family: \$2,000 or \$4,000

Copay:

Generic: \$10 Brand Name: \$25

**Note: There is no mail order available when ordered through a non-participating pharmacy.**

Coinsurance:

Generic: 100% after the Deductible and Copay

Brand Name when no generic equivalent available: 50% after the Deductible and Copay

Brand Name when Generic is available: After You meet the deductible and pay the \$10 Generic Copay, You are responsible for 100% of the difference between the cost of the Generic and Brand Name drug.



Eligible Expenses for Outpatient Prescription Drugs

**DO NOT** include:

1. Any Ancillary Drug Charge included in the cost of the Prescription Drug.
2. The cost of any Prescription Drug dispensed in a quantity that exceeds a thirty-one (31) day supply unless the packaging of the manufacturer or the prescription requires a greater quantity. Insulin is limited to the lesser of three vials and one hundred disposable syringes or a thirty-one (31) day supply of each.
3. DDAVP (desmopressin acetate) or other Prescription Drugs used in the treatment of primary nocturnal enuresis (bedwetting) for a Covered Person under the age of six.
4. Retin- A (tretinoin) for a Covered Person age 26 or older.
5. Contraceptives, including oral Prescription Drugs, implant Prescription Drugs or devices that are prophylactic or preventative in nature. We will not apply this Exception to a contraceptive Prescription Drug that is Medically Necessary for the treatment of an existing Sickness that the Group Policy would otherwise cover.
6. RU-486, which is taken to end pregnancy.
7. Devices or appliances including, but not limited to, blood glucose testing devices and support garments and bandages, except when Doctor prescribed.
8. Over-the-Counter (OTC) medications. An OTC medication means medication that a person can legally obtain without a Doctor's prescription; compounded drugs, unless they contain one 'legend' ingredient; unit dose drugs; dietary supplements, herbs and vitamins. We will not apply this Exception to prenatal vitamins a Doctor prescribes for pregnancy.
9. Prescription refills:
  - In excess of the number specified in the Doctor's prescription; or
  - Dispensed more than one year after the initial prescription date.
10. Prescription Drugs that a Doctor administers or dispenses while in his office or while a Covered Person is in a facility that provides medical care, including unit dose Prescription Drugs and any supplies.
11. Prescription Drugs that a Doctor prescribes for:
  - Cosmetic purposes;
  - Treatment of hair loss;
  - Care, services or treatment that the Group Policy does not cover; or
  - Treatment of an Injury or Sickness that the Group Policy does not cover.

12. Prescription Drugs used for the purpose of:
  - Losing weight;
  - Treating Acne (including Accutane);
  - Promoting growth (for example: growth hormone);
  - Treating sexual dysfunction or inadequacy; or
  - Facilitating smoking cessation (including any Prescription Drug containing nicotine or its derivatives).
13. Prescription Drugs that a Doctor prescribes for the treatment of mental illness, chronic fatigue syndrome or fibromyalgia.
14. The Prescription Drug Viagra.
15. Any Prescription Drug that is not consistent with the diagnosis and treatment of the Covered Person's Injury or Sickness because:
  - The Prescription Drug is excessive in terms of the scope, duration or intensity of scope;
  - The duration or intensity of Prescription Drug therapy is excessive in terms of what is needed to provide safe, adequate and appropriate care; or
  - The Prescription Drug is solely for the Covered Person's, Covered Person's family or Doctor's convenience.
16. Prescription Drugs prescribed for the replacement of lost or stolen prescriptions.

**Information you should know:**



**When Coverage Begins**-We require evidence of insurability before coverage is provided. Once we have approved Your Enrollment Application, and other conditions remain as described in the Enrollment Application, coverage for You and those dependents listed in the Enrollment Application and accepted by Us will begin on the Certificate Date shown in the Certificate Schedule.

**Newborn and Adopted Children**-A child born to You, adopted by You or a child placed for adoption with You is automatically covered from birth, date of adoption or date placed for adoption for 31 days when they are living with you.

To continue the child as a Covered Person, You must notify the company of the child's birth, date of adoption or date of placement for adoption and pay the additional premium for the child not later than 62 days following the child's date of birth, date of adoption or placement for adoption.

**Pregnancy**- Coverage for normal pregnancy is not provided. Complications of Pregnancy will be covered as a Sickness only if: (1) the Covered Person's coverage is in force at the time the expense is incurred as a result of such complications; and (2) the eligible charge results solely from the Complications of Pregnancy.

This brochure contains a brief description of the coverage under the Group Policy Form SLA-P06. Coverage may vary depending upon Your state of residence. Consult Your agent for specific exceptions or changes. The Group Policy is the contract of insurance. Your Certificate describes in greater detail the rights and obligations of both You and the insurance company under the Group Policy. It is, therefore, important that You read Your Certificate carefully. A sample is available, please ask your agent.

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**Travel Overseas**-Your coverage remains in effect for Emergency treatment while traveling outside of the United States.

**Other Insurance Benefits**-This Plan has a Coordination of Benefits provision which is a method of coordinating benefits payable under more than one insurance plan so that benefits from all sources do not exceed 100% of a Covered Person's Allowable Expense.

**Injury to Teeth**-Treatment necessitated by Injury to sound natural teeth, which occurs after coverage under the base plan, becomes effective for a Covered Person while such coverage remains in effect, shall be an eligible expense. All other dental expenses are not eligible expenses.

**Cosmetic Surgery**- We do not provide benefits for plastic, cosmetic or reconstructive surgery, including breast reduction and surgery to repair, replace or remove breast implants. However, we do provide benefits if surgery is:

- (a) To correct damage for a covered Injury or Sickness;
- (b) To repair a birth defect of a child born to You or adopted by You and continually covered under the Group Policy from its birth; or
- (c) For reconstructive surgery following a covered mastectomy.

**Premium Changes**-We will not change Your premium prior to the first anniversary of the Certificate Date, unless Your coverage or residence changes. After the first anniversary of coverage, We may change premium as a result of a change in Your age or residence or anytime, and from time to time, that we decided to change rates for persons in your or a Covered Person's class. We will give You 30 days notice before any premium change. The new rates will apply on a class basis as determined by Standard Life.

**Pre-Existing Conditions**- means a condition not otherwise excluded by name or specific description: (1) for which medical advice, testing, care, treatment or medication was given or was recommended by, or received from, a Doctor within twelve months before the Certificate Date; or (2) that would have caused a reasonably prudent person to seek medical diagnosis or treatment within twelve months before the Certificate Date. A pregnancy existing on the Certificate Date is a Pre-Existing Condition. The Company does not cover Pre-Existing Conditions for the first twelve months of coverage.

The Pre-Existing Condition provision does not apply to a covered person who enrolled as a HIPAA Eligible individual.

**Termination of Coverage**- We or the Group Policyholder can terminate or non-renew coverage under the Group Policy as of any premium due date under any of the following conditions:

- (a) You failed to pay premiums or contributions in accordance with the terms of the Group Policy or We have not received timely premium payments;
- (b) You or a Covered Person has performed an act or practice that constitutes fraud or made misrepresentation of material fact in applying for coverage or under the terms of the Group Policy;
- (c) You no longer reside, live or work in the PPO service area or in an area where We have authority to do business. We will only apply this provision if We end coverage uniformly and without regard to any health status related factor of a Covered Person (applicable only to the PPO plan);
- (d) We cease to offer coverage in the association market in accordance with applicable state law; or
- (e) We are discontinuing all health benefit plans offered to associations.

In the event of termination or non-renewal of coverage, the Company will give You notice as required by law.

At the time of coverage renewal, We may modify coverage under the Group Policy. However, the modification must be consistent with State law and effective on a uniform basis among all individuals that We cover under the Group Policy.

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**Exceptions:**

**WE DO NOT COVER AN INJURY OR SICKNESS THAT WE HAVE EXCLUDED BY NAME OR DESCRIPTION.**

**THE GROUP POLICY DOES NOT PROVIDE COVERAGE FOR LOSS CAUSED BY, CONTRIBUTED TO OR RESULTING FROM:**

1. Injury or Sickness if the loss is covered under these or similar laws:  
Worker's Compensation Law;  
Employer's Liability Law; or  
Occupational Disease Law.
2. Injury or Sickness that results from war or an act of war, whether war is declared or not.
3. Care or supplies that a Covered Person receives in a Hospital or other facility that a government agency runs. However, We will not apply this Exception if:
  - (a) The Covered Person receives a charge that he has to pay by law; and
  - (b) The Hospital or facility would have made the charge even if no insurance existed.
4. Eligible Expenses relating to the diagnosis and/or treatment of the adenoids, tonsils, gallbladder, reproductive organs, and hernia for the first six months of coverage. However, if We have excluded any one of these conditions by rider, We do not pay any benefit for the condition, regardless of when the treatment takes place; or if such condition is a Preexisting Condition, any benefit consideration will be in accordance with the Preexisting Conditions provision.
5. Eligible Expenses resulting from procedures or treatments that are Experimental or Investigational Medicine.
6. Organ Transplants, except as otherwise provided under the section titled Organ Transplants.
7. Pregnancy and childbirth, except for Complications of Pregnancy.
8. Mental or Nervous Disorders.
9. Plastic, cosmetic or reconstructive surgery. This Exception includes breast reduction and surgery to repair, replace or remove breast implants. This Exception does not apply when surgery is required:
  - (a) To correct damage for a covered Injury or Sickness;
  - (b) To repair a birth defect of a child born to You and continuously covered under the Group Policy from its birth; or
  - (c) For reconstructive surgery following a covered mastectomy.
10. Dental Treatment unless due to Injury to a Covered Person's natural teeth.
11. Eligible Expenses for a Pre-Existing Condition for the first 12 months of coverage.
12. Any attempt at suicide or any intentionally self-inflicted Injury.
13. A Covered Person's commission of or attempt to commit a felony, or an illegal act or being engaged in an illegal occupation.
14. Charges for, or relating to, any loss that results from:
  - (a) A Covered Person, voluntarily or involuntarily, administering, taking or injecting any drug, sedative or narcotic unless taken as a Doctor prescribes; or

(b) Injuries to a Covered Person while the person was operating a motor vehicle and his blood alcohol content exceeded 0.08% by weight, whether or not the Covered Person's use of alcohol causes or contributes to the Injury.

15. Charges relating to radial keratotomy, laser surgery, or any type of surgery or procedure, for refractive correction, eye refraction or the purchase or fitting of vision or hearing aids, Cochlear Implants and related devices.
16. Charges relating to treatment of obesity, including exogenous, endogenous, morbid obesity, or weight reduction.
17. Mandibular or maxillofacial surgery to:
  - (a) Correct growth defects;
  - (b) Correct jaw disproportions or malocclusions;
  - (c) Increase vertical dimension; or
  - (d) Reconstruct occlusion after one year from a child's date of birth or a child's date of adoption.

We do not apply this Exception for the repair of a congenital anomaly or birth defect of a child born to You or a child that You adopt. The Group Policy must continuously cover the child from birth, adoption or placement for adoption.

18. Treatment provided outside the United States of America, its possessions and territories, except as otherwise provided under Foreign Emergency Treatment.
19. Diagnosis or treatment (including surgery) of sexual dysfunction disorder or inadequacy; transsexual surgery.
20. Sclerotherapy for veins of the extremities or laser surgery to minimize veins.
21. Care received in a Rehabilitation Facility, including services of this type rendered in a separate section of a building that houses an Acute Care Facility.
22. Routine newborn care, unless otherwise stated in the Group Policy.
23. Care in a nursing home, custodial institution or domiciliary care or rest cures.
24. Eligible Expenses for charges that You or a Covered Person are not legally obligated to pay.
25. Benefits that Medicare pays.
26. Charges for which benefits are not specifically provided in the Group Policy.
27. Medicines or Drugs, treatment or procedure that either promotes or prevents contraception or prevents childbirth including and relating to, but not limited to: (a) artificial insemination; (b) in-vitro fertilization or any other diagnosis or treatment for the control, promotion or enhancement of fertility; (c) treatment for impotency, including Viagra; (d) sterilization or reversal of prior sterilization; or (e) elective or non-Medically Necessary and therapeutic abortion, including the Drug RU-486, unless the life of the mother would be endangered if the fetus were carried to term.
28. Medicines or Drugs or medicinal supplies when a Covered Person is not Hospital Confined.

## 29. Treatment of Alcoholism

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**Notice to Applicant:**

This description of the Information Practices of Standard Life and Accident Insurance Company is being provided in accordance with the requirements of the Insurance Information and Privacy Protection Law. Requirements may vary by state. Please consult your agent.

**Collection of Information:**



Federal and state laws require notification that, in connection with your application, we may require an investigative consumer report. In addition, such report may be requested subsequently to update our records or if you apply for additional coverage. Upon written request, we will inform you whether or not an investigative consumer report was requested and, if such report was requested, the address and telephone number of the investigative agency to which the request was made. By contacting the local office and providing proper identification, you may inspect or for an appropriate fee, receive a copy of such report.

Typically, the report will contain information as to character, general reputation, personal characteristics and mode of living, which information is obtained through an interview with you or an adult member of your family, employers or business associates, financial sources, friends, neighbors or others with whom you are acquainted. The information will consist, when applicable, of a confirmation of your identity, age, residence, marital status, and past and present employment including occupational duties, financial information, driving record, sports and recreational activities, health history, use of alcohol or drugs if any, living conditions and type of community.

Information regarding your insurability will be treated as confidential. Standard Life and Accident Insurance Company, or its reinsurers may, however, make a brief report thereon to the MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB upon request will supply such company with information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

Standard Life and Accident Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Please be assured that the above describes some of the disclosures which may be made, not disclosures which are always made. In any event, the information disclosed without your authorization will be only as much as reasonably necessary to accomplish this intended purpose. The types of information disclosed will vary depending upon the needs of the recipient and the sensitivity of the data. A description of the circumstances under which information about you might be disclosed without your authorization, to the types of persons and organizations referred to above, will be sent to you upon request.

## **Obtaining Additional Information:**

We at Standard Life and Accident Insurance Company hope that you will find this description of our information practices helpful. We take our responsibility, and you rights, very seriously. If you have any further questions about the items discussed above, please write to us at One Moody Plaza, Galveston, Texas 7755

### **STANDARD LIFE AND ACCIDENT INSURANCE COMPANY**

#### ***NOTICE OF PRIVACY PRACTICES***

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information.  
Please review it carefully.**

**If you have any questions about this Notice, please contact:**

**Morris Soler, FLMI  
Privacy Officer  
1 Moody Plaza,  
Galveston, Texas 77550  
HIPAA.COMPLIANCE.OFFICER@ANICO.COM  
409.766.6420**

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to protect the privacy of your information, provide this notice about our information practices, and abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You can request a copy of our notice at any time.

#### **Uses and Disclosures of Protected Health Information**

We use protected health information about you for health care operations, underwriting, claims processing and policyholder service. For example, we would use or disclose protected health information to MIB, a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members.

Any other uses or disclosures of your protected health information will be made only with your written authorization. You may revoke this authorization at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

We may use or disclose identifiable health information about you without your authorization for other reasons. Subject to certain requirements, we may disclose protected health information without your consent or authorization as for public health purposes, for auditing purposes, for research studies, and for emergencies. We also provide protected health information when otherwise required by law, or for law enforcement purposes, legal proceedings, military activity and national security, to a coroner, funeral director or medical examiner, and when required by the Secretary of the Department of Health and Human Services.

This brochure contains a brief description of the coverage under the Group Policy FormSLA-P06. Coverage may vary depending upon Your state of residence. Consult Your agent for specific exceptions or changes. The Group Policy is the contract of insurance. Your Certificate describes in greater detail the rights and obligations of both You and the insurance company under the Group Policy. It is, therefore, important that You read Your Certificate carefully. A sample is available, please ask your agent.

## Your Rights

Although your health record is the physical property of Standard Life and Accident Insurance Company, the information belongs to you. You have the right to:



- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of privacy practices upon request
- inspect and obtain a copy of your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose protected health information except to the extent that action has already been taken

You have the right to inspect and copy your protected health information for as long as we maintain the protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. Please contact our Privacy Contact if you have questions about access to your records.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree to a restriction that you may request. If we agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction. You may request a restriction by submitting a letter to the Health Underwriting Department, P.O. Box 1991, Galveston, Texas 77550.

You have the right to amend your protected health information. This means you may request an amendment of protected health information about you in a record for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact if you have questions about amending your records.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have a right to request receipt of confidential communications by alternative means or at alternative locations if you clearly state that disclosure could endanger you. You have the right to have this request reasonably accommodated.

You have the right to obtain a paper copy of this notice from us.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. You may contact our Privacy Contact, Morris Soler, HIPAA Privacy Officer, Standard Life and Accident Insurance Co. 1 Moody Plaza, Galveston, Texas 77550, [hipaa.compliance.officer@anico.com](mailto:hipaa.compliance.officer@anico.com), 409.766.6420 for further information about the complaint process.

This notice was published and becomes effective on April 14, 2003.

## Rating Classes

### *Only applies to Catastrophic Hospital and HSA Plans*

Rating classes are determined on an individual basis - each family member is evaluated individually.

Standard Life and Accident Insurance Company uses 4 rating classes.

- ✓ **Tobacco User:** This includes any proposed insured who has used tobacco products, including smokeless or chewing tobacco within the past 12 months prior to the application.
- ✓ **Standard:** This includes proposed insureds who have not used tobacco within 12 months preceding the application but are not eligible or do not qualify for the Preferred Rates.
- ✓ **Substandard:** This includes proposed insureds who would require an extra premium or exclusion waiver(s) for certain health conditions that are otherwise not insurable. This allows full coverage for the health condition(s). Medical waivers are available for proposed insureds with certain conditions that are otherwise not insurable.
- ✓ **Preferred:** To be eligible for the Preferred Rate Discount, the proposed insured must be 19 years or older and applying as a primary insured or spouse. Additionally, this class includes proposed insureds who are generally healthy and lead a healthy lifestyle. *If any of the following apply, preferred rates are not available.*

- ◆ Medical Exclusions / Rider
- ◆ Special Class Rating
- ◆ Answers "Yes" to any of the questions in the Preferred Rating Questionnaire

## Preferred Rating Questionnaire

	PROPOSED INSURED		SPOUSE	
	Yes	No	Yes	No
1. Have you used tobacco in any form in the past 12 months prior to the application?				
2. Does your weight fall outside the standard weight range listed on the build chart provided in the field Underwriting Manual?				
3. Have you had blood pressure readings in excess of 140/95 and/or been treated for hypertension in the past 2 years?				
4. Have you had cholesterol readings in excess of 300 and/or been treated for elevated cholesterol or triglycerides in the past 2 years?				
5. Have you had any convictions for OUI, DUI, DWI or more than 3 moving violations in the past 12 months?				
6. Have you taken any prescription medication in the past 2 years for a recurrent or chronic condition? (e.g. Reflux, Arthritis, or Asthma, etc.)				
7. Have you recently applied for coverage and been turned down, rated, or offered modified coverage within the past 12 months?				

Note: The proposed insured must complete and sign the appropriate sections. Spouses are considered separately for Preferred Rating eligibility and must also answer this questionnaire. This information is not required for dependent children. Underwriting reserves the right to apply tobacco ratings based upon lab results, telephone verification or medical records.

Proposed insured \_\_\_\_\_ Date \_\_\_\_\_

Spouse \_\_\_\_\_ Date \_\_\_\_\_

Drivers license number \_\_\_\_\_ State \_\_\_\_\_

Drivers license number \_\_\_\_\_ State \_\_\_\_\_

Licensed Agent \_\_\_\_\_ Date \_\_\_\_\_

Agent number \_\_\_\_\_



Enrollment Application to:  
STANDARD LIFE AND ACCIDENT INSURANCE COMPANY

New  Reinstatement  Change

**Catastrophic Hospital Plan**

**Plan Deductible Amount:**

\$750  \$1,500  \$2000  \$2,500  \$5,000  
 \$10,000  \$15,000

**Coinsurance:**

100%  80 %  50 %

**Stop-Loss Amount:**

\$5,000  \$10,000

**Optional Benefits:** (NOT AVAILABLE WITH HSA PLAN)

**OP Accident Rider:**

\$400  \$800  \$1,200

**Post Confinement Rider:**

\$1,200  \$2,400

**OP Doctor Rider:**

YES  NO

**PPO Rider:**

YES  NO

**OP Drug Rider:**

Individual Deductible

\$500  \$1,000

**Hospital Surgical Plan:**

(check one)

Option 1

Option 2

Option 3

Option 4

**Daily Hosp. Benefit Amt**

\$500

\$1,000

\$2,000

\$3,000

**HSA Plan**

**Deductible Amount:**

\$ \_\_\_\_\_

**Rate of Payment:**

100%  80%  50%

**PPO Rider:**

YES  NO

**Home**

**Office Use:**

**Special**

**Request:**

**1. SCHEDULE OF FAMILY MEMBERS - FIGURE HEALTH PREMIUM AT AGE LAST BIRTHDAY**

No. (Print Last Name, First Name, Middle Initial)	Tobacco User**	Relationship	Sex	Age	Date of Birth				Build		Health Premium
					Mo.	Day	Yr.	State	Height	Weight	
01		Proposed Insured									
02		Spouse									
03											
04											
05											

\*\*Write "Yes" or "No" if proposed insured has used any form of tobacco (including cigarettes, cigars, pipe or chewing tobacco) during the past twelve months.

\* **Pay Mode:**  MBD  Quarterly  Semi-Annually  Annually \* **Draft Initial Premium**  Yes  No \* **TOTAL PREMIUM \$**

2. Marital Status:  Single  Married

3. PROPOSED INSURED'S HOME ADDRESS:

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Tel. Number (\_\_\_\_) \_\_\_\_\_

4. BUSINESS INFORMATION: **Best time to call**  A.M.  P.M.

Full Business Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Bus. Tel. Number (\_\_\_\_) \_\_\_\_\_

5. Occupation & duties of adult family members?

(1) \_\_\_\_\_

(2) \_\_\_\_\_

6. Are all family members between the ages of 19 and 24 full-time students?

Yes  No If "No," which family member? \_\_\_\_\_

Explain \_\_\_\_\_

7. Are all proposed insureds legal citizens of the United States?  Yes  No

If "No", is the proposed Insured a permanent resident?  Yes  No

(If "No", this coverage cannot be provided). If "Yes", provide the following

information as shown on the permanent Card:

INS. #	Category	Resident Since	Card Expires

8. I am a member of the National Consumers Advantage Assoc.  Yes  No

9. Is any proposed insured or household member (including students away at school whether or not now applying for coverage) currently pregnant?

Yes  No If "Yes," who? \_\_\_\_\_

If "Yes", this coverage cannot be provided.

10. Does any family member proposed for insurance presently receive any

government aid such as Medicaid, Medicare or SSDI?  Yes  No

If "Yes," which family member? \_\_\_\_\_

Reason \_\_\_\_\_

11a. Have you been covered under a health insurance plan including COBRA within the last 18 months?  Yes  No

b. Are you applying for coverage under the federal HIPAA Program?

Yes  No If "Yes", please submit letter of creditable coverage with the application.

c. Is the insurance applied for intended to replace any existing insurance or insurance which has terminated with this company or any other company?  Yes  No If "Yes," to questions 11a and b provide details below for coverages in last 24 months.

Ques. #	Name of Company & Policy #	Plan Type Grp. or Ind.	Hospital	Maj. Med.	Effect. Dt. Mo-Yr	Term. Dt. Mo-Yr

12. Has any propose insured applied for life, accident or health insurance or for reinstatement of such insurance, which was declined, restricted or rated up? (Circle action)  Yes  No If "Yes," which person? \_\_\_\_\_

Date \_\_\_\_\_

Reason \_\_\_\_\_

Company \_\_\_\_\_

13. Within the last three years has anyone participated in: flying, scuba diving, mountain climbing, skydiving, hang-gliding, racing, motorcycling, rodeo, bungy jumping?  Yes  No If "Yes," who? (Circle activity) \_\_\_\_\_

14. Has any proposed insured had any arrests, a driver's license suspended, had any traffic violations or any prior DWI's and/or DUI's within the past 2 years?  Yes  No If "Yes," give details. \_\_\_\_\_

15. When was the last time each family member visited a doctor? Please provide details below for each member including regular attending physician.

Name	Condition, injury, symptoms, diagnosis	Onset Date Month/Year	Date of last treatment	Results/Degree of recovery	Name/Address Attending Physician

16. **Has any person proposed for insurance EVER had a history of, symptoms related to or been treated for disease or disorder of:** Yes No
- (a) The Circulatory System or heart, including but not limited to high blood pressure, heart attack, angina, heart murmur, irregular heartbeat, open heart surgery, angioplasty, stent placement, congenital disorders, stroke, carotid or peripheral artery disease, valve disorder or replacement, varicose veins, blood clots, chest pain, elevated cholesterol or transient ischemic attack?.....
- (b) The Endocrine System, including but not limited to diabetes, glucose elevation or intolerance, hypoglycemia, or disorders of the thyroid, parathyroid, pituitary, adrenal or thymus gland?.....
- (c) The Immune System, including but not limited to blood or spleen disorder, leukemia, lymphoma, purpura, lymphadenopathy, or connective tissue disease such as lupus, scleroderma, etc.?.....
- (d) The Respiratory System, including but not limited to asthma, allergies, bronchitis, emphysema, Chronic Obstructive Pulmonary Disease (COPD), tuberculosis, lung disorder, reactive airway disease, or sleep apnea?.....
- (e) The Urinary System, including but not limited to kidney or bladder disorders, renal stones, urinary tract infections, ureteral or renal reflux, cystitis, pyelitis, or abnormal urine values such as sugar, albumin, blood and bacteria or sexually transmitted disease?.....
- (f) The Gastro-Intestinal System, including but not limited to liver, pancreas, stomach, intestines, gall bladder, esophagus, rectum, ulcers, reflux, hepatitis, colitis, pancreatitis, hernias, inflammatory bowel disease, hemorrhoids?.....
- (g) The Skin or subcutaneous tissues, including but not limited to burns, scars, dermatitis, eczema, psoriasis, acne, cellulitis, or hemangiomas?.....
- (h) The Muscular-Skeletal System, including but not limited to the back, spine, muscle, bone, joint, hip, knee, arm, or foot disorder, arthritis, gout, rheumatism, bursitis, neuritis, myositis, fibromyalgia, sciatica, motor skill delay or received chiropractic/manipulative therapy?.....
- (i) The facial bones/jaws, including but not limited to temporomandibular joint disease (TMJ), cleft palate/lip, overbite and underbite?.....
- (j) The Nervous System, including but not limited to brain, nerve and spinal cord disorders, epilepsy/seizures, narcolepsy, fainting spells, dizziness, paralysis, tremors, palsy, head or nerve injury, headaches, stroke, transient ischemic attack, meningitis, encephalitis, or neuritis?.....
- (k) Cancer in any form, including in-situ and skin, tumor, cyst, polyp, or growth of any kind?.....
- (l) The ears, eyes, nose, throat disorders, including but not limited to ear infection, ear tubes, impaired hearing, vertigo, cataracts, glaucoma, impaired vision, tonsil infections/enlargement, sinusitis, speech impairment?.....
- (m) Mental/nervous system, including but not limited to emotional problems, Attention Deficit Disorder disorder/hyperactivity, Autism, anxiety, depression, insomnia, eating disorder, developmental delay, panic or social disorders, or receiving psychological counseling or treatment?.....
- (n) The Male Reproductive Organs/Breasts, including but not limited to, prostate hypertrophy, prostatitis, elevated PSA (prostate specific antigen), testicular disorders, impotence, infertility, breast disorder, or sexually transmitted disease?.....

17. **Questions A-D for female proposed insureds only:**
- (a) Within the last 10 years has any person proposed for insurance ever had any indication of, diagnosis of, or treatment for any disorder or condition of the female reproductive organs, abnormal pap smear, irregular or excessive menstruation, endometriosis, infertility, pregnancy complications, including Cesarean Section Delivery, cystocele, rectocele, pelvic relaxation, dysmenorrhea, chronic pelvic pain or HPV (Human Papilloma Virus)?.....
- (b) Date of last Pap Smear? \_\_\_\_\_ Results \_\_\_\_\_
- (c) Have you been instructed to have a repeat Pap smear or any follow up treatment or tests as a result of your Pap smear?.....
- (d) Has any person proposed for insurance ever had a breast disorder, disease, changes, condition or lump(s), aspiration(s), biopsies including removal or placement of breast implants, mammoplasty, or calcifications?.....

18. Within the past 12 months, has any proposed insured experienced or been treated by a physician for:
- (a) Weight gain or loss of more than 12 pounds?  Yes  No (b) Recurrent episodes of diarrhea?  Yes  No
- (c) Swollen or enlarged glands or lymph nodes?  Yes  No
- (d) Persistent cough, persistent or recurrent fever, 10 or more viral infections?  Yes  No (e) Chronic or recurrent skin rashes?  Yes  No

19. Within the past 5 years, has any proposed insured:
- (a) Been hospital confined, had surgery or discussed surgery, medical treatment or testing including cosmetic or reconstructive surgery with a doctor?.....
- (b) Had an EKG or other heart study, ultrasound, MRI, chest x-ray, blood study, contacted or seen a physician, psychologist, chiropractor, counselor, therapist or any other person providing health care services?.....

20. Has any proposed insured ever been:
- (a) Treated or counseled for alcohol use or attended Alcoholics Anonymous or other drug or alcohol support group?.....
- (b) Treated or counseled for drug dependency, abuse or reactions?.....
- (c) A user of any drug not prescribed including, but not limited to opiates, cocaine, stimulants, depressants, and/or hallucinogens or cautioned about using drugs or alcohol to excess?.....

21. Does any person have any fixation/prosthetic devices present including but not limited to plates, screws, pins, orthotics, implants, shunts, pacemakers, valves, joint replacements or stents?.....
22. Is any proposed insured currently taking medication or receiving treatment of any kind?.....
23. Does any person proposed for insurance have any other injuries, abnormalities, health conditions, medical or surgical advice, hospitalizations, treatments or operations not mentioned above?.....
24. Has any proposed insured ever tested positive on HIV-related test or been diagnosed by a physician as having HIV, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?.....

25. **IMPORTANT! Details to Questions 16-24 Give complete details of any "Yes" answer.**

Question #	Name	Condition, injury, symptoms, diagnosis	Onset Date Month/Year	Date of last treatment	Results/Degree of recovery	Name/Address of Attending Physician

(If more space is needed, attach a supplement and sign it. Check this box  if supplement is attached.)

**DECLARATION AND AGREEMENTS**

I declare that the statements and answers in the application are complete and true to the best of my knowledge and belief and all information given to the agent has been recorded correctly and in its entirety. I agree that: (a) this application will form a part of the contract; (b) the agent does not have the authority on behalf of the Company to accept risks, or to make, alter or amend the coverage or to extend the time for making any payment due on such coverage; and (c) no insurance will take effect unless and until the application is approved by the Company and the certificate is delivered to the proposed insured during the lifetime and good health of all persons proposed for insurance, the conditions affecting insurability are and have remained as described herein and the first premium has been paid in full. I hereby acknowledge receipt of a copy of the Fair Credit Reporting Act and Medical Information Bureau notices.

**Insurance Fraud - Warning:** 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 may be guilty of insurance fraud.

I have truly and accurately recorded the information as supplied by the proposed insured and members. I have left a brochure that outlines the coverage.

Signed X \_\_\_\_\_  
Agent Signature

Agent's Name \_\_\_\_\_  
Print Agent's Name Agent No.

I UNDERSTAND THAT COVERAGE IS NOT EFFECTIVE UNLESS AND UNTIL APPROVED AND ISSUED BY THE COMPANY.

Dated at: \_\_\_\_\_ 20\_\_\_\_  
City State Month Day Year

Signed X \_\_\_\_\_  
Signature of Proposed Insured

Signed X \_\_\_\_\_  
Signature of Spouse (required if applying for coverage)

I have personally witnessed/verified the Proposed Insureds identity through a U.S. Federal or state government-issued photo I.D.

Drivers License  Passport  Government-issued identification  Other \_\_\_\_\_

**AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION**

I hereby authorize any physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policy holder, employer, benefit plan administrator, The Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency, or an independent administrator, including medical record retrieval services, pharmaceutical services, acting on STANDARD LIFE AND ACCIDENT INSURANCE COMPANY or its reinsurers behalf, information concerning advice, care or treatment sought by or provided to me and/or any other proposed insured for coverage, including information relating to medical history, medical conditions; treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the proposed insured(s). It is understood that Standard Life and Accident Insurance Company, underwriters, claims examiners, reinsurers, attorneys or the medical director may disclose such health information to the aforementioned parties for compliance, record clarification or explanation, or in response to litigation, summons or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it resulting in loss of protection by federal regulations.

I understand that:

- (1) such information will be used by STANDARD LIFE AND ACCIDENT INSURANCE COMPANY for underwriting and insurability determinations;
- (2) I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain health insurance coverage;
- (3) a picture copy or photocopy of this authorization shall be as valid as the original; and
- (4) any authorized representative of the proposed insured is entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months or until the person is no longer covered. I understand I may revoke the authorization at any time, except to the extent that actions have been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, P.O. Box 1991, Galveston, Texas 77553. I may inspect or copy any information used or disclosed under this authorization, if signed.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Proposed insured's Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Spouse's Signature (if coverage is requested for spouse)

Personal Representative designated by signature above is hereby authorized to execute this instrument based on: power of attorney, guardian-in-fact, guardian, payee representative, other \_\_\_\_\_ (Circle one)



**MODIFICATION OF HEALTH INSURANCE APPLICATION  
attached to Certificate No.**

To STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, Galveston, Texas:

I hereby agree that the application submitted by me for the certificate to which this  
modification Rider is attached be amended as follows:

The following information is included as part of the application made to the Company.

Question Number	Person (Line #)	Symptom or Condition	Treatment, Advice Given, Results and other details	Name, Address, Telephone # of Doctors & Hospital

This Amendment shall become a part of the certificate to which it is attached and be subject to the policy provisions.

\_\_\_\_\_


Dated at \_\_\_\_\_ Date \_\_\_\_\_

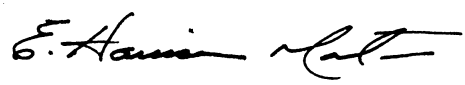
(City) (State)

\_\_\_\_\_ Signed

\_\_\_\_\_ Witness \_\_\_\_\_ Proposed insured

In Witness, Whereof, STANDARD LIFE AND ACCIDENT INSURANCE COMPANY has caused this Amendment to be executed on the later of the Effective Date shown in the Schedule page of the certificate, or the Effective Date shown above.

  
Secretary

  
President

# Health Insurance Portability and Accountability Act of 1996

## *What is HIPAA?*

HIPAA is the Health Insurance Portability and Accountability Act of 1996.

Passed by Congress in August of 1996; it was effective July 1, 1997.

HIPAA provides certain Americans guaranteed access to health insurance coverage regardless of existing health conditions.

## *Do I qualify for guaranteed access to health insurance?*

If all of the following statements apply to you, you are an Eligible Individual under HIPAA and you qualify for guaranteed access. As of the date on which you apply for coverage.

1. You have had prior creditable coverage for a period in the aggregate of 18 or more months and your most recent prior Creditable Coverage was under a group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with any such plan);
2. You are not eligible for coverage under a group health plan, part A or part B of Medicare, or Medicaid (or any successor program) and do not have other health insurance coverage;
3. Your most recent coverage within the coverage period described in paragraph (1), above, was not terminated based on nonpayment of premiums or fraud;
4. You were offered the option of continuation coverage under a COBRA continuation provision or under similar State program, and you elected such coverage and have exhausted such continuation coverage under such provision or program.

## *What is Creditable Coverage?*

Creditable Coverage means, with respect to an individual, coverage of the individual under any of the following:

1. A group health plan.
2. Health insurance coverage.
3. Medicare
4. Medicaid
5. Health insurance plans for members of the U.S. Armed Forces and their dependents.
6. A medical care program of the Indian Health Service or of a tribal organization.

7. A State health benefits risk pool.
8. Health insurance plans for employees of the U.S. Government and their dependents.
9. A public health plan (as defined in regulations).
10. A health benefit plan under section 5(e) of the Peace Corps Act (22-2504(e)).

A period of Creditable Coverage shall not be counted if there was more than a 62- day period during all of which the individual was not covered under any Creditable Coverage.

## *What is Eligible Individual?*

Eligible Individuals are the only people who have guaranteed access to health insurance under HIPAA. HIPAA requires health insurance carriers to allow guaranteed access to certain plans, at the carrier's election (Federal Fallback), unless a state adopts an Alternate Mechanism. Under HIPAA, Alternative Mechanisms include high risk pools, guaranteed issue requirements for one or more plans and other methods to assure the access requirements of HIPAA are followed.

## *What alternative mechanism did my state adopt?*

Your SLAICO agent can tell you specifically, but generally states have created risk pools or adopted Federal Fallback positions. In states which have adopted risk pools as an Eligible Individual you have 62 days (Eligibility Period) from the date your last employer-sponsored coverage terminated to obtain coverage through the pool. **IF YOU FAIL TO MAKE THE APPLICATION TO THE POOL IN THE REQUIRED TIME PERIOD, THE POOL DOES NOT HAVE TO PROVIDE COVERAGE.** If you have exhausted any portion of your Eligibility Period, you should strongly consider making application directly to the pool. You may apply to SLAICO in the interim, but you will NOT have guaranteed access and will be subject to full underwriting and other limitations provided under the policy.

If your state is a Federal Fallback state, SLAICO is required to provide you guaranteed access to health insurance. You may elect to apply for coverage through either policy form, SLAP-06 or SLAP-06H. However, optional benefits will not be available.

PLEASE SIGN THE STATEMENT BELOW AND RETURN IT TO YOUR AGENT.

I, \_\_\_\_\_  
hereby acknowledge that I have received and read the material contained in this leaflet describing the rights of Eligible Individuals under HIPAA and understand its content.

\_\_\_\_\_  
*Recipient's Signature* Date \_\_\_\_\_

Name of Agent \_\_\_\_\_

## Confirmation of Presentation

At my request, the agent whose signature appears below, visited me to determine my interest in applying for health insurance with Standard Life and Accident Insurance Company. The agent informed me he was authorized to sell insurance for Standard Life and Accident Insurance Company, (the "Company"). The agent was courteous and fully explained to me all the provisions of the group insurance plan including benefits, exclusions, limitations, waiting periods, coordination of benefits and deductibles if any, and answered all my questions to my satisfaction.

Proposed insured and agent acknowledge that the agent asked each and every question on the enrollment application. The answers on the application are my truthful and complete answers with nothing left out that proposed insured in any way related or stated to the agent. **I signed the application only after a full review of the questions and answers had been filled in. I, the proposed insured, fully understand and agree that if any material information is omitted from the application, it could provide the basis for the Company to deny future claims, refuse coverage and to refund premiums as though the certificate had never been in force.**

### Proposed insured's initials

The agent informed me that the amount of the initial insurance premium which I have delivered to him will be held by the Company. The Company will distribute the current National Consumer Advantage Association membership dues to the National Consumer Advantage Association. The agent informed me that in the event coverage is not approved, all amounts paid will be refunded to me as applicable.

In signing this form, I agree I have carefully examined and understand the materials provided to me and the application, and that neither the agent nor the Company is bound by any knowledge or statements made by the agent or me, unless set forth in writing in the application and receipt.

**I acknowledge confirmation of presentation. I understand that coverage is not effective unless and until approved as applied for by the Company. This confirmation of presentation was attached to a brief description of coverage which I received from the agent.**

Signed this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

Proposed Insured's Signature \_\_\_\_\_ Agent's Signature \_\_\_\_\_

**STANDARD LIFE AND ACCIDENT INSURANCE COMPANY**  
ONE MOODY PLAZA  
GALVESTON, TEXAS

**IMPORTANT INFORMATION CONCERNING THE HEALTH INSURANCE COVERAGE THE AGENT HAS JUST DESCRIBED TO YOU. THIS DOCUMENT MUST BE READ AND COMPLETED BY YOU PRIOR TO FILLING OUT THE APPLICATION FOR INSURANCE COVERAGE**

**THE HEALTH INSURANCE COVERAGE THE AGENT HAS JUST DESCRIBED TO YOU IS NOT DESIGNED NOR INTENDED AS A HEALTH INSURANCE PLAN TO BE PROVIDED BY AN EMPLOYER FOR EMPLOYEES.**

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED:

- 1. Are you the owner of an incorporated business?  Yes  No
- 2. Are you a sole proprietor or a partner in a partnership?  Yes  No
- 3. Are you an employee of a business?  Yes  No
  - a. Will your employer pay a portion of your health insurance premium?  Yes  No
  - b. Will you be reimbursed by your employer, through wage adjustments or otherwise, for any portion of the premium?  Yes  No
  - c. Will your health insurance plan be treated by you or your employer as part of a plan or program for the purposes of Section 106, 125 or 162, Internal Revenue Code of 1986 (26 U.S.C. Section 106, 125 or 162)?  Yes  No

**I hereby declare that the answers provided to the questions above are true and correct and agree they will be used to determined my eligibility for coverage under the health insurance plan, indicated below (the "Plan"). I will notify the Company of any change in my employment status and I will provide the Company with any evidence required by it to determine my future eligibility under the Plan, I understand and agree that:**

- 1. a future change in my employment status may cause me to no longer be eligible for the Plan as of the date of change;
- 2. eligibility for the Plan does not constitute initial coverage under the Plan; and
- 3. initial coverage under the Plan is subject to the Company's underwriting criteria.

Signed on \_\_\_\_\_, 20 \_\_\_\_\_ at \_\_\_\_\_

Agent's Signature (as witness) \_\_\_\_\_ Proposed insured's Signature \_\_\_\_\_

Agent's Name (Please print.) \_\_\_\_\_ Proposed insured's name (Please print.) \_\_\_\_\_

Agent number \_\_\_\_\_

Plan:  Catastrophic Hospital Expenses Plan  
 Other: \_\_\_\_\_

**EMPLOYEE CENSUS FORM**  
FOR  
**STANDARD LIFE AND ACCIDENT INSURANCE COMPANY**

Company Name: \_\_\_\_\_

Address : \_\_\_\_\_

Street

City

State

Zip Code

Mailing

Address: \_\_\_\_\_ ( ) \_\_\_\_\_ ( )

(If Different)

(Telephone Number)

(Fax Number)

Nature of Business: (Specific) \_\_\_\_\_

Type of Ownership:     Sole Proprietorship     Partnership     Corporation

Number of Employees: \_\_\_\_\_

I certify that the information furnished to the Company is correct and complete. I understand that the Company intends to rely on this information in determining the eligibility of the individual(s) who have made application for insurance. I further understand that the Company may periodically request information to determine continued eligibility and I agree to provide any information required for such determined.

By: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Please Print

Agent: \_\_\_\_\_ Agent Signature: \_\_\_\_\_

Please Print

Agent Code: \_\_\_\_\_

## AUTOMATIC PAYMENT AUTHORIZATION

FOR THE PURPOSE OF HONORING CHARGES INITIATED BY STANDARD LIFE AND ACCIDENT INSURANCE COMPANY  
& NATIONAL CONSUMER'S ADVANTAGE ASSOCIATION  
**PRINT NAME OF DEPOSITOR AS IT APPEARS ON BANK RECORDS**

Policy No. :	FULL NAME OF BANK	
Bank Acct. No. : BRANCH NAME AND NO. (IF ANY)	CITY AND STATE	TRANSIT NO. AND ROUTING SYMBOL

**To: STANDARD LIFE AND ACCIDENT INSURANCE COMPANY AND NATIONAL CONSUMER'S ADVANTAGE ASSOCIATION**

- (1) I hereby request and authorize either or each of you to draw on my checking account maintained at my bank, (named above) for the payment of dues for National Consumer's Advantage Association or of monthly premiums on the above insurance policy. It is agreed that: You shall make such charge electronically or, at you discretion, in writing. It will not be necessary for your officer or employee of **STANDARD LIFE AND ACCIDENT INSURANCE COMPANY AND NATIONAL CONSUMER'S ADVANTAGE ASSOCIATION** to sign such items.
- (2) The issue and presentation for payment of such items shall be a waiver of any requirement for notices of premiums due. The cancelled check or other evidence of payment provided by my bank will constitute a premium receipt. The use of this plan shall in no way alter or amend the provisions of the policy with respect to termination of such policy upon non-payment of the premium due.
- (3) You shall incur no liability by reason of dishonor of any such item.
- (4) If this authorization pertains to a policy for which application is pending, it shall not become effective unless and until such policy is issued and delivered and shall relate only to premiums thereafter falling due.
- (5) If this authorization pertains to a policy previously issued, this shall constitute an election of this special mode of premium payment which shall continue in effect only so long as premiums are paid under this plan. Premiums will then revert to regular method payment, depending upon minimum premium requirements.
- (6) This agreement shall continue in effect unless terminated by you or me with 30 days written notice to the other party, except that you may terminate this agreement immediately if any item is not paid upon presentation.

**X**

DATE

BANK SIGNATURE OF DEPOSITOR

Make Checks Payable To:  
**National Consumer's Advantage Association**

**ATTACHED AN UNSIGNED  
VOIDED CHECK**

32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	16	15	14	13			

## AUTOMATIC PAYMENT AUTHORIZATION

FOR THE PURPOSE OF HONORING CHARGES INITIATED BY  
**STANDARD LIFE AND ACCIDENT INSURANCE COMPANY AND NATIONAL CONSUMER'S ADVANTAGE ASSOCIATION**

As a convenience to me, I hereby request and authorize you to pay and charge to my bank checking account items payable to the order of the Company, provided there are sufficient collected funds in said account to pay the same upon presentation. It will not be necessary for any officer or employee of the Company to sign any such item. I agree that your rights in respect to each such item shall be the same as if it were a check drawn to you and signed personally by me. I further authorize the Company to transmit such items to you electronically, if you are or become a member of the Automated Clearing House System, or in writing, if you are not such a member. I agree that all transactions shall be subject to the rules of the Automated Clearing House System. This authority is to remain in effect until revoke by me in writing, and until you actually receive such notice that I agree that you shall be fully protected in honoring such item.

I further agree that if any such item be dishonored, whether with or without cause and whether intentionally or inadvertently, neither you nor any bank participating under the Automated Clearing House Rules, shall be under any liability whatsoever even though such dishonor may result in the foreclosure of insurance.

Bank (You) \_\_\_\_\_ Name of Customer (me) \_\_\_\_\_  
Please Print

Branch \_\_\_\_\_ Bank Transit No. \_\_\_\_\_ Date \_\_\_\_\_

Street Address \_\_\_\_\_ **X** \_\_\_\_\_  
CUSTOMER'S SIGNATURE

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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**To: THE BANK NAMED ON THE REVERSED SIDE**

So that you may comply with your depositor's authorization and direction as set forth on the reverse side hereof, the Company agrees:

- (1) To indemnify you and hold you harmless from any loss you may suffer as consequence of your actions resulting from or in connection with the execution, issuance, or transmission or any such item, whether or not genuine, purporting to be executed or transmitted by this Company and received by you in the regular course of business for the purpose of payment of such insurance premiums, including any costs or expenses reasonably incurred in connection therewith.
- (2) In the event that any such check shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor results in a forfeiture of the insurance.
- (3) To defend at our own cost and expense, any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.

STANDARD LIFE AND ACCIDENT INSURANCE COMPANY  
(THE COMPANY)



Secretary