



Underwritten by NOVA Casualty Company
AIM Select Series
Enrollment Application Kit

Please review the checklist below before you send your Enrollment Application.

PLEASE PRINT CLEARLY AND USE BLACK INK TO COMPLETE APPLICATION

- Complete Section 1 and Section 2 and sign where applicable.
- Complete the premium calculation on page one and initial.
- Complete the Existing Insurance Acknowledgement Form if you currently have health Insurance.
- Application must be received by the 15th of prior month to be approved for the 1st of the following month.
- Application must be received by the 1st of the month to be approved for a 15th of the same month.
- Paying via Credit Card is subject to a 3% additional charge
- No charge for monthly Electronic Fund Transfers (EFT).
- Must pay first month's (premium, administration fee, association dues & one time enrollment fee).

Paying via EFT: Include copy of a voided check with Enrollment Application.

Paying via EFT: Fax completed Enrollment Application to:
Fax: 866-436-1640
ATTN: ENROLLMENT DEPARTMENT

A Defined Benefit Health Insurance Plan for AIM Members

Not a Major Medical Plan

Section 1 - Enrollment Worksheet - PLEASE PRINT CLEARLY IN BLACK INK

Rep Name	Rep Signature	Date	Telephone	Agent Code
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EFFECTIVE COVERAGE DATE: _____

APPLICATION TYPE: OPEN ENROLLMENT ENROLLMENT CHANGE

PROVIDER NETWORK: MultiPlan

SELECT PLAN & TIER	Select Bronze	Select 500	Select 1000	Select 2000
Insured Only	<input type="checkbox"/> \$145.00	<input type="checkbox"/> \$204.00	<input type="checkbox"/> \$293.00	<input type="checkbox"/> \$374.00
Insured + Spouse	<input type="checkbox"/> \$197.00	<input type="checkbox"/> \$302.00	<input type="checkbox"/> \$477.00	<input type="checkbox"/> \$693.00
Insured + Child(ren)	<input type="checkbox"/> \$187.00	<input type="checkbox"/> \$284.00	<input type="checkbox"/> \$442.00	<input type="checkbox"/> \$634.00
Family	<input type="checkbox"/> \$229.00	<input type="checkbox"/> \$365.00	<input type="checkbox"/> \$599.00	<input type="checkbox"/> \$901.00

SELECT RIDER(S) & TIER	\$10,000 Critical Illness	\$500 Daily Hospital	\$5,000 Accident	\$10,000 Accident
Insured Only	<input type="checkbox"/> \$32.00	<input type="checkbox"/> \$41.00	<input type="checkbox"/> \$25.00	<input type="checkbox"/> \$35.00
Insured + Spouse	<input type="checkbox"/> \$52.00	<input type="checkbox"/> \$65.00	<input type="checkbox"/> \$25.00	<input type="checkbox"/> \$35.00
Insured + Child(ren)	<input type="checkbox"/> \$32.00	<input type="checkbox"/> \$88.00	<input type="checkbox"/> \$25.00	<input type="checkbox"/> \$35.00
Family	<input type="checkbox"/> \$52.00	<input type="checkbox"/> \$88.00	<input type="checkbox"/> \$25.00	<input type="checkbox"/> \$35.00

Total Premium Calculation

AIM SELECT SERIES ELIGIBILITY

Individuals eligible to apply for coverage:

1. Individuals ages 18-64 and dependent children under age 19.
2. Unmarried dependent children with proof of full-time student status between the ages of 19-25.
3. Individuals not in full-time service of the Armed Forces (military)
4. Individuals not eligible for Medicare
5. Individuals not receiving disability benefits or worker's compensation.

Pre-existing conditions:

Pre-existing conditions are not covered until the policy has been in effect for more than 12 months. A pre-exist-ing condition is any condition you have now or had within a 12 month period prior to the effective date of cover-age for each covered person. The Health USA Plan is HIPAA compliant. Persons who leave the plan will receive a HIPAA Certificate of Creditable Coverage. Those who enter the plan presenting a valid Certificate of Creditable Coverage will receive credit toward this plan's pre-existing conditions limitation.

Terms of coverage:

Coverage remains in effect as long as you pay the required premium charges on time, and as long as you maintain membership eligibility. Coverage will be terminated if you become ineligible due to any of the following circumstances: a) Non-payment of premiums and fees, b) Residency requirements, c) For other reasons permissible by law.

Enter Plan Premium	\$ _____
Enter Rider(s) Premium (If Applicable)	\$ _____
Total Regular Monthly Premium	\$ _____
One Time Enrollment Fee	\$ <u>85.00</u>
Total First Month's Premium Including One Time Enrollment Fee (Due at time of Application)	\$ _____

X _____ By initialing this section I understand that the premiums above are monthly premiums. In addition, I understand that my Total First Month's Premium will include the "One Time Enrollment Fee." I further understand that the "One Time Enrollment Fee" is a non-refundable fee once the application has been submitted.

OFFICE USE ONLY

Name of Group:	Group Number:		
Date Submitted:	Approved By:	Processed By:	Date Processed:

Section 2 - Personal Data & Billing Election - PLEASE PRINT CLEARLY IN BLACK INK

APPLICANT NAME (Last,First Middle Initial)		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	BIRTHDATE (mm/dd/yyyy)	SOCIAL SECURITY NUMBER
STREET ADDRESS		CITY	STATE	ZIP CODE
BILLING ADDRESS (If different than above)			EMAIL ADDRESS	
HOME TELEPHONE	WORK PHONE	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		DATE of EVENT (If applicable)
EMERGENCY CONTACT (Name)	RELATION	CONTACT NUMBER	ALTERNATE CONTACT NUMBER	

Note: If you are applying for coverage for your spouse and/or child(ren), please list each one below. See Eligibility Guidelines on previous page. Please indicate additional dependents on a duplicate page if necessary.

LAST NAME	FIRST NAME	RELATIONSHIP	GENDER	SOCIAL SECURITY NUMBER	BIRTHDATE (mm/dd/yyyy)	Check if over 19 & disabled.
SPOUSE		<input type="checkbox"/> WIFE <input type="checkbox"/> HUSBAND	<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/>
Dependent		<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/>
Dependent		<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/>
Dependent		<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/>
Dependent		<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/>

ELECTION OF COVERAGE AND AUTHORIZATION*

The applicant in consideration of membership in the Association and participation in the plan hereby acknowledges that the Association, its third party administrator, their agents, owners, successors and assigns assumes no liabilities or obligations other than those specifically identified. I hereby agree to indemnify them from and against any and all claims, damages, losses, costs or expenses (including, without limitation, attorneys fees and disbursements) for any claims that may arise by the participation of the plan or membership in the association. I understand that pre-existing conditions will not be covered during the first 12 months of the contract unless I present evidence of prior creditable coverage. All information provided above is true and complete to the best of my knowledge. 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, shall be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Disclaimer IMPORTANT! Our medical plan is a low-cost alternative, providing medical insurance at fixed amounts, and these limited benefits are paired with medical discounts to designated providers. My signature below indicates that the limitations of the plan have been disclosed & explained to me and that I understand and accept said plan designs. My signature below also indicates I would like to enroll in the limited medical health plan I selected above. All applicants must sign below. Any false statement will be cause for immediate cancellation of coverage. It will take one week after your effective date for your cards and provider books to arrive.

PRIMARY APPLICANT SIGNATURE (REQUIRED) X	PRINT NAME	DATE
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PAYMENT OPTIONS- All payments will reflect Insurance Resource Group as billing company.

AUTOMATIC MONTHLY ELECTRONIC FUNDS TRANSFER (EFT) - PLEASE ATTACH A VOIDED CHECK

INITIAL PAYMENT: Please EFT my bank account for the first month's premium, administration fee, association dues and the one time enrollment fee. This will occur about 5 to 7 days before your effective date of coverage.

MONTHLY PAYMENT: Please EFT my bank account for the monthly premium, administration fee and association dues. This will occur about 5 to 7 days prior to your monthly effective date.

BANK NAME	BANK ROUTING NUMBER	BANK ACCOUNT NUMBER
ACCOUNT HOLDER SIGNATURE (REQUIRED) X	PRINT NAME	DATE

AUTOMATIC MONTHLY CREDIT CARD PAYMENTS (There is a 3% additional monthly fee on entire premium payment)

INITIAL PAYMENT: Please charge my credit card for the first month's premium, administration fee, association dues and the one time enrollment fee. This will occur about 5 to 7 days before your effective date of coverage.

MONTHLY PAYMENT: Please charge my credit card for the monthly premium, administration fee and association dues. This will occur about 5 to 7 days prior to your monthly effective date.

<input type="checkbox"/> VISA	<input type="checkbox"/> MasterCard	<input type="checkbox"/> DISCOVER
CARD NUMBER	EXPIRATION DATE	CVV2 SECURITY CODE
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>

Card Back

4465 9991 333

CVV2 Security Code

CARD HOLDER SIGNATURE (REQUIRED) X	PRINT NAME	DATE
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DIRECT MONTHLY BILL - There is a \$10.00 additional monthly billing fee for this option.

INITIAL PAYMENT: I am paying the first month's premium, administration fee, association dues and the one time enrollment fee. I am sending a check or money order with my completed Enrollment Application. **There is a \$30 insufficient funds fee.**

MONTHLY PAYMENT: I would like to receive a monthly invoice to pay my monthly premium, administration fee, association dues and \$10 statement fee.

Existing Insurance Acknowledgement Form

ALSO REQUIRED	
Are you covered by any other health insurance plan?	
Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
(If yes, please complete the form below)	
Insurance Company:	
Name:	
Street Address:	
City:	
ST:	
Zip:	
Policy Number:	
Effective Date:	