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 applied to the entire monthly premium.

☐ 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

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	☐ $125.00	☐ $157.00	☐ $222.00	☐ $287.00
Insured + Spouse	☐ $172.00	☐ $231.00	☐ $355.00	☐ $518.00
Insured + Child(ren)	☐ $164.00	☐ $218.00	☐ $330.00	☐ $474.00
Family	☐ $198.00	☐ $277.00	☐ $444.00	☐ $670.00

SELECT RIDER(S) & TIER	$10,000 Critical Illness	$500 Daily Hospital	$5,000 Accident	$10,000 Accident
Insured Only	☐ $32.00	☐ $41.00	☐ NA	☐ NA
Insured + Spouse	☐ $52.00	☐ $65.00	☐ NA	☐ NA
Insured + Child(ren)	☐ $32.00	☐ $88.00	☐ NA	☐ NA
Family	☐ $52.00	☐ $88.00	☐ NA	☐ NA

Total Premium Calculation

Enter Plan Premium	$ ______________
Enter Rider(s) Premium (If Applicable)	$ ______________
Total Regular Monthly Premium	$ ______________
One Time Enrollment Fee	$ 85.00
Total First Month's Premium Including One Time Enrollment Fee (Due at time of Application)	$ ______________

AIM SELECT SERIES ELIGIBILITY

Individuals eligible to apply for coverage:

1. Individuals ages 18-64 and dependent children under age 25.
2. Individuals not in full-time service of the Armed Forces (military)
3. Individuals not eligible for Medicare
4. 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 Select Series 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.

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 ☐ Male ☐ 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 ☐ Single ☐ Married ☐ Divorced ☐ 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	☐ WIFE ☐ HUSBAND	☐ Male ☐ Female			☐
Dependent	☐ SON ☐ DAUGHTER	☐ Male ☐ Female			☐
Dependent	☐ SON ☐ DAUGHTER	☐ Male ☐ Female			☐
Dependent	☐ SON ☐ DAUGHTER	☐ Male ☐ Female			☐
Dependent	☐ SON ☐ DAUGHTER	☐ Male ☐ Female			☐

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

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.

☐ VISA ☐ MasterCard ☐ DISCOVER

CARD NUMBER ____-____-____-____

EXPIRATION DATE M M Y Y

CVV2 SECURITY CODE

Card Back
4465 9991 333
CVV2 Security Code

CARD HOLDER SIGNATURE (REQUIRED) X	PRINT NAME	DATE

☐ **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:		No:	

(If yes, please complete the form below)

Insurance Company:	
Name:	
Street Address:	
City:	
ST:	
Zip:	
Policy Number:	
Effective Date:	