

**American Alternative Insurance Corporation - Princeton, NJ
Temporary Health Insurance Application Colorado Only**

ADMIN. USE ONLY
CASE # _____

The Policy does not provide portability of prior coverage. As a result, any injury, sickness, or pregnancy for which you have incurred charges, received medical treatment, consulted a health care professional, or taken prescription drugs within 12 months of the effective date of the policy will not be covered under the Policy.

1	A. Requested Effective Date ____/____/____ You may request a specific effective date (may be any day of the month) as long as the application and premium are received by Allied before the requested effective date. See brochure for details on effective dates.	B. PLAN OPTIONS: <input type="checkbox"/> Monthly Billing <input type="checkbox"/> Prepay Plan – Number of Months (1 to 6) _____ Deductible: <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,250 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 Maximum Coverage Period: Six (6) Months – This coverage does not renew <input type="checkbox"/> I am applying for Child Only coverage				
	APPLICANT'S NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME) _____ SOCIAL SECURITY NUMBER _____					
2	RESIDENCE ADDRESS _____					
	CITY _____ STATE _____ ZIP _____ DAYTIME TELEPHONE (Include Area Code) _____					
3	BILLING NAME/ADDRESS (IF DIFFERENT THAN ABOVE) PLEASE INCLUDE FULL MAILING ADDRESS AND PHONE NUMBER _____					
	APPLICANT'S DATE OF BIRTH _____	AGE _____	GENDER _____	Applicant – Must be over age 17 and under age 65 (unless applying for child only coverage) Spouse – Must be under age 65 Dependent Children – Must be under age 19		
	Complete this section to Insure your spouse and/or children					
4		FULL NAME (First Name, Middle Initial, Last Name)	DATE OF BIRTH	AGE	GENDER	SOC. SEC. NUMBER
	Spouse					
	Child #1					
	Child #2					
5	Please answer the following questions completely and accurately (any "YES" answer means coverage cannot be issued):					
	A. Are you over age 64, or is your Dependent Spouse to be insured over age 64, or is any Dependent Child to be insured over age 18? <input type="checkbox"/> YES <input type="checkbox"/> NO					
	B. Are you or any Dependent to be insured covered under other hospital, major medical, group health or other medical insurance coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO					
	C. Are you or any Dependent to be insured a member of the armed forces of any country, state or international organization, other than on reserve duty for 30 days or less? <input type="checkbox"/> YES <input type="checkbox"/> NO					
	D. Are you or any Dependent to be insured currently pregnant, or if insuring dependents, are you an expectant father or planning on adopting? <input type="checkbox"/> YES <input type="checkbox"/> NO					
	E. Within the last five (5) years, have you or any Dependent to be covered been hospital confined for five (5) consecutive days or longer? <input type="checkbox"/> YES <input type="checkbox"/> NO					
	F. Within the last five (5) years, have you or any Dependent to be covered seen any medical professional, been recommended to see a medical professional, been treated, received medication or received abnormal test results for, or been diagnosed with, any of the following conditions? <ul style="list-style-type: none"> • Cancer (excluding basal cell), Diabetes, Hepatitis, Liver Disorder, Polycystic Kidney Disease, Renal Failure, AIDs or tested positive for HIV (WI applicants do not need to disclose HIV test results); • Heart disorder – including but not limited to chest pain, heart failure, rhythm disturbances or heart attack; • Circulatory system disorder – including but not limited to stroke or deep vein thrombosis/phlebitis; • Nervous System disorder – including but not limited to Muscular Dystrophy; or • Mental/Nervous disorder, Substance Abuse or Alcoholism requiring hospitalization..... <input type="checkbox"/> YES <input type="checkbox"/> NO 					
	G. Do you or any Dependent to be insured have <u>either</u> high blood pressure or elevated cholesterol (whether or not treated or controlled), and weigh more than 300 pounds if male or 250 pounds if female? <input type="checkbox"/> YES <input type="checkbox"/> NO					
	H. If <u>all</u> persons to be insured are United States citizens, please answer "No" to this question. If any person to be insured is <u>not</u> a United States citizen, has that person resided outside the United States at any time over the last 24 months? <input type="checkbox"/> YES <input type="checkbox"/> NO					
	I. Have you or any other person to be insured been covered under two or more individual Short-Term policies during the past 12 months? <input type="checkbox"/> YES <input type="checkbox"/> NO If "Yes", then this policy may not be issued. You must wait 6 months from the date of your last such policy to apply for a Short-Term policy.					
I understand or acknowledge the following: (a) This is not a continuation of any previous medical plan, including any prior temporary health insurance plan; (b) If the application is declined and coverage is not issued, American Alternative Insurance Corporation's only obligation will be to return any premium paid; and (c) I received and reviewed the plan brochure, which serves as an outline of coverage. It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. I authorize the disclosure of all nonpublic personal information and individually identifiable protected health information for me (and my dependent(s), if requesting dependent coverage), including but not limited to employment status, other insurance coverage, diagnosis, prognosis, medical treatment or care and physical or mental conditions (including alcohol or drug dependency), by any physician, medical practitioner, hospital, other medical related facility, insurance company, employer or benefit plan having such information, to the Insurance Company or its legal representative, agent or vendor, for the purpose of approving enrollment and processing claims. I acknowledge and agree that this authorization shall be valid for two (2) years; that I may revoke it in writing at any time; that I may request a copy of this authorization; that enrollment and the processing of claims are not conditioned on my signing this authorization; that this authorization will be used as its own document, separate from the application; that a photocopy of this authorization shall be as valid as the original; and that I have authority to act as the personal representative of my dependent(s) (if requesting dependent coverage).						
Applicant's Signature _____		Date _____				
STM 2006-2.IA (CO)		Underwritten by American Alternative Insurance Corporation		Policy Form #STM 2006-2		

Colorado law requires carriers to make available a Colorado Health Benefit Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within 3 business days to a potential policyholder who has expressed interest in a particular plan or who has selected the plan as a finalist from which the ultimate selection will be made. The carrier also must provide the form, upon oral or written request, within 3 business day, to any person who is interested in coverage under or who is covered by a health benefit plan of a carrier.

OPTIONAL AUTHORIZATION AGREEMENT FOR AUTOMATIC MONTHLY PREMIUM PAYMENTS

I authorize Allied National to charge my account as indicated below for my monthly insurance premium and fees. I understand my account will be charged once each month for the total amount shown as due on my monthly premium statement for the limited term of the policy of insurance issued to me. I understand that if a charge to my account is not honored, my insurance coverage could lapse prior to its termination date. I understand that if I wish to cancel my coverage prior to its termination date, I must inform Allied National of such cancellation prior to the end of the grace period corresponding to the date of cancellation. Please charge my monthly premium and fees against the following account.

NAME (as shown on account – please print) _____

CREDIT CARD: MasterCard Visa – Account Number _____ Expiration Date _____

CHECKING/NOW ACCOUNT: Please attach a voided check from the account you wish billed for your coverage.

SIGNATURE _____ DATE _____

COLORADO AREA FACTORS

(based on first 3 digits of zip code of the residence address)

800-804..... 1.50
805-816..... 1.40

This Plan is available in other states. Please contact Allied for state availability

RATES/AREAS EFFECTIVE 1/1/08

Rates \$750 Deductible			Rates \$1,250 Deductible			Rates \$2,500 Deductible		
Age	Male	Fem.	Age	Male	Fem.	Age	Male	Fem.
thru age 29	\$44	\$53	thru age 29	\$37	\$44	thru age 29	\$28	\$33
30-34	\$51	\$66	30-34	\$43	\$55	30-34	\$32	\$41
35-39	\$63	\$80	35-39	\$53	\$67	35-39	\$39	\$50
40-44	\$76	\$94	40-44	\$64	\$79	40-44	\$48	\$59
45-49	\$94	\$107	45-49	\$79	\$89	45-49	\$59	\$67
50-54	\$121	\$130	50-54	\$101	\$109	50-54	\$76	\$81
55-59	\$170	\$157	55-59	\$142	\$131	55-59	\$106	\$98
60-64	\$230	\$211	60-64	\$192	\$176	60-64	\$144	\$132
Per Child.....	\$38		Per Child ...	\$32		Per Child....	\$24	

RATE LOAD FACTORS		
EFFECTIVE DATE	PREPAY	MONTHLY
1/1/08 – 3/31/08	1.00	1.25
4/1/08 – 6/30/08	1.03	1.29
7/1/08 – 9/30/08	1.06	1.33
10/1/08 – 12/31/08	1.09	1.36

A. Applicant \$ _____
 B. Spouse +\$ _____
 C. Child(ren) +\$ _____
 D. Subtotal =\$ _____
 Area Factor X _____
 Load Factor X _____
 E. Premium Subtotal (round to nearest \$) =\$ _____
 F. Monthly Fee +\$ 12.00
 G. Total Monthly Cost =\$ _____

PREPAY PLAN ONLY

H. Number of Months X _____
 I. Prepay Total Cost =\$ _____

RATE CALCULATION:

1) Determine rates based on deductible chosen and sex and age of each person. For child(ren) rate multiply number of children by the per child rate.
 2) Multiply the subtotal (D) of these rates by the Area Factor and the Rate Load Factor to get Premium Subtotal (E) and round to nearest dollar. The Rate Load Factor is determined by the requested effective date and whether choosing Prepay or Monthly billing.

3) Add Monthly Fee to get Total Monthly Cost (G).
 4) For Prepay ONLY – multiply G times number of months requested for Prepay total Cost (I).
NOTE- Business checks cannot be accepted. Payment must be made by credit card or personal check payable to Allied National. Online enrollment and rating is available at tempmedsales.alliednational.com

AGENT INFORMATION

SOLICITING AGENTS SIGNATURE _____ DATE _____

Soliciting Agent's Name _____ Agency _____ Allied Agent # _____

Address _____ City _____ State _____ Zip _____

Tel. () _____ Pay Commissions to: _____ SS# or Tax ID# _____

Fax () _____ EMAIL _____

1) **Is the soliciting agent a licensed agent in the applicant's state of residence?**
 Yes – If Yes, please send copy of state license. No – If No, the agent is not authorized to solicit this coverage and the policy cannot be issued.
 2) **Is the soliciting agent currently appointed with American Alternative Insurance Corporation:**
 Direct with American Alternative Insurance Corporation? or Through ALLIED or another Administrator? WHO? _____

Appointment fees: Allied National will pay fee for agent appointment.

DISTRIBUTORS/GENERAL AGENT NAME: