AMERICAN COMMUNITY
MUTUAL INSURANCE COMPANY
39201 Seven Mile Road, Livonia, Michigan 48152-1094

MICHIGAN APPLICATION
for Non-Renewable Short Term Major Medical Expense Policy

For Home Office Use Only
Policy No. ____________

If children are to be insured, include all children, stepchildren and legally adopted children of the applicant, who are dependent on the applicant and 15 days old, but have not reached their 22nd birthday.

PLEASE PRINT IN BLACK INK Full Name	Sex	Relationship	Date of Birth	Age	Place of Birth	In USA Yrs.	In USA Mo.	Marital Status
		Applicant						

RESIDENT ADDRESS

________________________ City ____________ State _____ Zip Code ________ County ____________

RESIDENT PHONE NUMBER
( ) ____________ Daytime
( ) ____________ Evening

APPLICANT'S SOCIAL SECURITY NUMBER ____________
APPLICANT'S DRIVER'S LICENSE NUMBER ____________
SPOUSE'S DRIVER'S LICENSE NUMBER ____________

POLICY DATE / REQUESTED DATE

❑Day After Postmark ❑Specific Date _____/_____/_____
Month Day Year

QUESTIONS APPLY TO EACH PERSON PROPOSED FOR INSURANCE. IF ANY OF THE FOLLOWING QUESTIONS ARE ANSWERED "YES", SUCH PERSON IS INELIGIBLE FOR THE POLICY.

If "yes", who:

1. Have you, or any person to be insured, lived in a country other than the United States, Australia, Canada, England, Ireland, New Zealand or Scotland in the past 12 months? ❑ Yes ❑ No ____________
2. Do you or any person to be insured have any hospital, major medical, group health, Medicaid or medical insurance coverage in force that will not terminate prior to the effective date of this coverage? ❑ Yes ❑ No ____________
3. Is any person to be insured now pregnant, an expectant father or planning to adopt a child within the term of the policy? ❑ Yes ❑ No ____________
4. Have you, or any person to be insured ever been declined for insurance due to health reasons? ❑ Yes ❑ No ____________
5. Within the last five years, have you, your spouse or any dependent to be insured, sought advice, been diagnosed or received any medical or surgical treatment, including medication, from a medical professional for: stroke, the heart including but not limited to: irregular heart beat, heart murmur, heart attack, chest pain, high blood pressure, blood clot, liver disorder, kidney disorder, diabetes, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immune Deficiency Syndrome), immune disorders, cancer or tumor, emphyzema, alcoholism or alcohol abuse, drug abuse or chemical dependency? ❑ Yes ❑ No ____________

I have read this application and represent that the information shown on it is true and complete, to the best of my knowledge and belief. I understand and agree that:

1. Coverage, if issued, will become effective on the policy date, and that no benefits are payable for an injury sustained before the policy date or sickness first manifestedbefore the policy date.

2. Each person named in questions 1 through 5 is excluded from coverage under this policy.

3. The policy I am applying for is not a renewal or extension of any previous coverage and does NOT cover any condition for which benefits were paid under a previous policy.

4. I acknowledge that I have been provided with a Notice of Your Privacy Rights.

THIS IS LIMITED COVERAGE. PRE-EXISTING CONDITIONS ARE NOT COVERED. ALTERED APPLICATIONS WILL NOT BE ACCEPTED.

Signed at ________________________ Date ________________________
City & State Month/Day/Year

____________________ Signature of Applicant
____________________ Signature of Spouse (if proposed for insurance)
____
____________________ Signatures of Dependents (age 16 and over)

____________________ Signature of Licensed Resident Agent
____________________ Agent's Name - Please Print
____________________ Agent's Number
____________________ Agent's Phone Number

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 is guilty of insurance fraud.

600A MI 1/05

PLEASE COMPLETE THE REVERSE SIDE.

NOTICE OF YOUR PRIVACY RIGHTS

Please detach and leave for applicant

We know that your trust in us is very important. We are committed to protecting your privacy rights. Please read this document carefully. It discloses your privacy rights.

Obtaining Information About You - We may obtain information from your application, a telephone interview with you, claims history with us, policies you have or had with us, account balances and premium payment history, and other sources, such as health care providers (medical information), and consumer reporting agencies (credit reports). Your address, birthday, telephone number, social security number are examples of such information. An investigative consumer report may be prepared where information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted to obtain information as to your character, general reputation and personal characteristics. You may have to share such information with us, our affiliates, agencies or others working with us.

Our Use of Personal Information - We will share such information only with companies associated with us. We, or your agent or broker may use your information to offer you products or help you choose a product.

We may, as permitted by the law and without your prior approval, give information about you to persons who do business for us, your agent or broker, other insurance companies, or other persons handling your business, insurance company support organizations, regulatory or law enforcement authorities; and our affiliated companies. Information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons.

Your Rights

- The right to access, inspect and copy the personal information pertaining to you that we maintain in our files about you.
- The right to request that we correct or amend any personal information that we have about you.
- To request an interview in connection with the preparation of an investigative consumer report.

To exercise these rights, please send a written request to the attention of the Privacy Coordinator.

How We Protect Your Personal Information - We protect the information we share with companies working for us through an agreement. The agreement obligates those companies to keep your information confidential.

Only our employees who work to service your business see your personal information. We have trained our employees to closely follow our privacy rules for your protection. Your privacy rights will continue if you cease to be our customer.

THE REMAINDER OF 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.

We are required to maintain the privacy of your personal medical information and provide you with this notice as to our legal duties and privacy practices. We are required to abide by the terms of this notice. We reserve the right to change the terms of this notice and to make any new provisions effective to all of the medical information that we maintain about you. If we revise this notice, we will provide you with a revised notice by mailing the revised notice to the address you have supplied us.

STATEMENT OF YOUR RIGHTS

You have the right to know how we use or disclose your personal medical information. There are certain uses and disclosures of your personal medical information that we are permitted or required to make by law without your permission. In addition, you have:

- The right to request that we place additional restrictions on our uses and disclosures of your personal medical information, but we are not obligated to agree to any such restrictions.

- The right to access, inspect and copy the protected information pertaining to you that we maintain in our files, and the right to request that we correct or amend any personal medical information that we have about you.
- The right to receive an accounting of the disclosures of your personal medical information that we make for purposes other than activities related to your treatment, or our payment functions or other health care operations.
- The right to request that you receive communications of personal medical information in a confidential manner.
- The right to obtain a paper copy of this notice from us on request.

To exercise these rights please send a written request to the attention of the Privacy Coordinator.

PERMISSIBLE USES AND DISCLOSURES OF PROTECTED MEDICAL INFORMATION

Payment Functions. We may use or disclose your protected medical information without your permission to carry out activities relating to reimbursing you for the provision of health care, obtaining premiums, determining coverage, and providing benefits under the policy of insurance that you are purchasing. For example, payment functions may include (but are not limited to) reviewing health care services with respect to medical necessity, coverage under the policy, appropriateness of care, or justification of charges.

Health Care Operations. We may also use or disclose your protected medical information without your permission to carry out certain insurance-related activities. For example, these activities include using your protected information for underwriting, premium rating, or other activities relating to the creation, renewal or replacement of another contract of health insurance, placing a contract for reinsurance of risk relating to claims for health care, and performing audit functions to ensure compliance and proper claims payment.

Group Health Plan. We may disclose your protected medical information to your employer as necessary for the purpose of reporting claims experience or conducting an audit if you are covered under an employer-based group health insurance plan.

Business Associates. We may disclose your protected medical information to our business associates. There are some services provided in our company through contracts with our business associates.

Uses Permitted By Law. We may also use or disclose your protected medical information without your written permission for purposes permitted or required by law.

Authorized Uses. All other disclosures of your protected medical information will be made only with your written permission, and any permission that you give us may be revoked by you at any time.

COMPLAINTS ABOUT MISUSE OF INFORMATION - If you believe your privacy rights have been violated you may complain either directly to us or to the Secretary of Health and Human Services (H.H.S.). Please submit all complaints in writing and to us or H.H.S. as follows:

American Community Mutual Insurance Company
Attn: Privacy Officer
39201 Seven Mile Road
Livonia, MI 48152

U.S. Department of Health and Human Services
Attn: Secretary
200 Independence Ave S.W.
Washington, DC 20201

You will not be retaliated against in any way for filing a complaint.

OBTAINING FURTHER INFORMATION - Please call us if you have any questions or comments. The phone number is 1-800-991-2642

Effective Date: April 14, 2003

SHORT TERM MAJOR MEDICAL

TERM OF INSURANCE

❑ 1 Month ❑ 2 Months ❑ 3 Months
❑ 4 Months ❑ 5 Months ❑ 6 Months

PLAN

Deductible ❑ $250 ❑ $500 ❑ $1,000 ❑ $2,500

Coinsurance ❑ 80/20 of $5,000 ❑ 50/50 of $5,000

PAYMENT MODE

❑ Monthly Payment
❑ Lump Sum Payment

NONSUFFICIENT FUNDS FEE

If any premium payment made directly by check or by EFT (electronic funds transfer) is returned for nonsufficient funds, a $20 nonrefundable service fee will be applied.

TOTAL PREMIUM ENCLOSED $ ____________________

Payment Method:

❑ Check
❑ Automatic Monthly Bank Draft (EFT)
complete EFT authorization form at right.
❑ VISA/Mastercard (Initial payment only)

I authorize American Community to bill my VISA or Mastercard for the total premium:

Acct. # ________________________ Exp. Date ___________

Accidental Death Benefit

______________________ ______________________
Primary Beneficiary Relationship

______________________ ______________________
Contingent Beneficiary Relationship

(Benefits for loss of life of your spouse, if covered under the certificate, will be paid to you.)

American Community Mutual Insurance Company

Authorization Information For Electronic Funds Transfer For Premium Payment

Electronic funds transfer is the automatic, monthly transfer of funds from your checking account to American Community Mutual Insurance Company for the express purpose of premium payment. The only participation requirement is that you maintain a regular checking account.

Name____

Address______________________________________

____

Telephone____________________________________

Account and Authorization Signature(s)____________

____

____

Financial Institution___________________________

Address______________________________________

____

Account Number______________________________

(Attach a blank check marked "void." A deposit slip is not acceptable.)

Authorization Agreement For Electronic Funds Transfer For Premium Payment

I authorize American Community Mutual Insurance Company of Livonia, Michigan to start an automatic periodic withdrawal against my checking account at the financial institution I have indicated. I also authorize the financial institution to charge these withdrawals to my checking account each month. The withdrawals are to pay premium for the policy for which I have applied. If the application for that policy is pending, there will be no withdrawal until the first premium due after my policy has been issued.

I understand that the withdrawal will be automatically made each month and will appear on my statement. I also understand that my policy may lapse if my checking account does not have sufficient funds at the time of withdrawal. I want this withdrawal to automatically continue until I write American Community telling them to stop. I agree to allow them reasonable time to do so (usually 14 days).

____
Signature of Key Applicant/Owner

____
Date Signed

Premium Calculations

	MALE	FEMALE	CHILD/ CHILDREN	
❶ Base Rate	______	______	______	
❷ Area Factor	x ______	x ______	x ______	
Monthly Premium	______	+ ______	+ ______	= ______

FIGURE HEALTH PREMIUM AT AGE LAST BIRTHDAY.

❶ 80/20 Benefit Percentage

Age	$250 Ded. M	$250 Ded. F	$500 Ded. M	$500 Ded. F	$1,000 Ded. M	$1,000 Ded. F	$2,500 Ded. M	$2,500 Ded. F
18-24	36	53	29	43	21	32	15	23
25-29	39	61	31	50	23	37	17	28
30-34	39	64	32	53	23	40	17	30
35-39	47	76	38	64	28	48	21	36
40-44	59	86	48	72	35	54	26	42
45-49	78	96	65	80	48	60	36	47
50-54	99	105	83	88	62	67	47	52
55-59	132	126	112	106	84	80	66	63
60-63	164	143	139	121	107	92	86	73
Child dep.	32	32	24	24	17	17	12	12

❶ 50/50 Benefit Percentage

Age	$250 Ded. M	$250 Ded. F	$500 Ded. M	$500 Ded. F	$1,000 Ded. M	$1,000 Ded. F	$2,500 Ded. M	$2,500 Ded. F
18-24	27	40	22	32	16	24	11	17
25-29	29	46	23	38	17	28	13	21
30-34	29	48	24	40	17	30	13	23
35-39	35	57	29	48	21	36	16	27
40-44	44	65	36	54	26	41	20	32
45-49	59	72	49	60	36	45	27	35
50-54	74	79	62	66	47	50	35	39
55-59	99	95	84	80	63	60	50	47
60-63	123	107	104	91	80	69	65	55
Child dep	24	24	18	18	13	13	9	9

❷ County	Area Factor
Macomb, Oakland, Wayne	1.63
Genesee	1.48
Monroe, St Clair	1.41
Lapeer, Washtenaw	1.28
Calhoun, Cass, Huron, Jackson, Kalamazoo, Lenawee, Livingston, Sanilac, Tuscola	1.22
Berrien, Clinton, Eaton, Hillsdale, Ingham, Ionia, Shiawassee, VanBuren	1.16
Alger, Baraga, Delta, Dickinson, Gogebic, Houghton, Iron, Kent, Keweenaw, Luce, Marquette, Menominee, Muskegon, Newaygo, Oceana, Ontonagon, Ottawa, Schoolcraft	1.05
Rest of State	1.10

TO CALCULATE MODAL PREMIUMS, MULTIPLY THE MONTHLY PREMIUM BY THE MODAL FACTOR. TO CALCULATE THE LUMP SUM PAYMENT, MULTIPLY THE MONTHLY PREMIUM BY THE NUMBER OF MONTHS OF COVERAGE.

Premium Modes:	Modal Factor
Lump Sum Payment	1.00
Electronic Funds Transfer (EFT)	1.05
Monthly Payment Premium	1.10