ASSURANT Health®

Client Tip Sheet

Georgia

Dental Coverage

Thank you for applying for Assurant Supplemental Coverage. Review the product brochure so you understand the benefits and limitations of the plan. Talk to your agent to make sure the plan you're applying for is best suited to your needs.

If you are applying for multiple products, you will need to complete a separate application for each one.

Follow these steps to enroll now!

1. Review the plan information in the brochure and with your agent. Determine which plan is right for you.
2. Decide who you want to cover – just you; you and your spouse; just your children; or your entire family.
3. Determine the appropriate rate for the coverage you select. You can use the rate sheet or your agent can run an automated quote and attach it to your application.
4. Start the application process by completing information about you and family members you would like to cover.
5. For quick response to your application, fully complete the application with your agent, including:
   - All required questions
   - Requested effective date
   - Signatures
6. Complete the Billing Form indicating the method of payment.
7. Your agent will submit the completed forms and keep you updated on the status of your application.

Mail Completed Application or Fax to: George E Daniel Jr CIC, CPIA

119 Donalson Street

Bainbridge, Georgia 39817

Phone & Fax 229-246-3342

Cell 229-416-7030

ASSURANT Health®

Assurant Supplemental Coverage
Dental Rate Sheet

Rates can be automatically generated online using EASE.

Get quick pricing information by completing the form below. Circle the rate(s) on the rate pages. Then copy the numbers into the Proposed Coverage section on this page.

Be sure this name matches the primary applicant's name on Line 1 of the application.

Complete the details below for the Primary applicant (PLEASE PRINT):

Last Name	First Name	MI	Date of Birth	State of Residence

If you include an EASE quote with the application, you do not need to complete this form.

Attention Agents: Be sure this sheet is complete and fax it along with the application to 414-299-6020. Provide your name and contact information to your client (you also can stamp the back of the brochure).

Proposed Coverage:

Plan: ☐ Level 1–Basic ☐ Level 2–Intermediate ☐ Level 3-Plus

Insured(s): ☐ Primary Monthly Premium: $ _____

☐ Spouse $ _____

☐ Number of Dependent Children _____ $ _____

TOTAL

Final rates may vary due to rounding.

Discounted Rates represent a 40% rate reduction if Dental and Medical applications are submitted together.

- Also applicable if Dental is sold with Assurant Affordable Health Access plans
- Does not apply to Short Term Medical plans.
- Only applicable to Basic and Plus Dental plans

Rates shown represent a 10% discount applied to adult rates when spouse coverage is purchased.

To determine the rate for more than 4 children, simply multiply the "1 child" rate by the number of children to be covered.

Dental Monthly Rates				Discounted Rate if purchased with an Assurant Health Medical Plan	
Per adult rate if spouse **is not** covered					
Age	**Basic**	**Intermediate**	**Plus**	**Basic**	**Plus**
18-30	15.50	26.50	35.40	9.30	21.24
31-40	15.50	26.50	42.50	9.30	25.50
41-50	15.50	26.50	51.00	9.30	30.60
51-60	15.50	26.50	61.20	9.30	36.72
61-64	15.50	26.50	67.30	9.30	40.38
Per adult rate if spouse **is covered**					
Age	**Basic**	**Intermediate**	**Plus**	**Basic**	**Plus**
18-30	13.95	23.85	31.86	8.37	19.12
31-40	13.95	23.85	38.25	8.37	22.95
41-50	13.95	23.85	45.90	8.37	27.54
51-60	13.95	23.85	55.08	8.37	33.05
61-64	13.95	23.85	60.57	8.37	36.34
Child Rates	**Basic**	**Intermediate**	**Plus**	**Basic**	**Plus**
1 child	13.20	21.90	28.30	7.92	16.98
2 children	26.40	43.80	56.60	15.84	33.96
3 children	39.60	65.70	84.90	23.76	50.94
4 children	52.80	87.60	113.20	31.68	67.92

This Rate Sheet is for use with product brochures and state variations which contain details of Assurant Supplemental Coverage - Dental Coverage and the optional benefits. The rates for this dental plan are only valid for plans issued with effective dates from September 1, 2010, and later. Rates quoted more than 30 days in advance of the requested effective date are subject to change and are not guaranteed. Issuance of coverage is subject to approval. This proposal is not an insurance contract. Only the actual contract provisions apply. The effective date of the quote does not guarantee coverage and is subject to change. Rates are based on primary's age as of the effective date of the plan. Final rates may vary. All rates are subject to underwriting approval.

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company.

Application Form for Dental Insurance

AGENT/AGENCY INFORMATION — PLEASE PRINT IN BLACK INK

Agent Name: George E Daniel Jr
Phone Number: 229-246-3342
Agent Number: 59990 0000
E-mail Address: dan@danielhealth.com
Key Agency Contact: George E Daniel Jr
Agency Name: George E Daniel Jr dba Danielhealth
Fax Number: 229-246-3342 Phone & Fax
Agency Number: 59991-0000

Policy should be mailed to: ☒ Agent ☐ Agency ☐ Policyholder

TYPE OF ACTIVITY *(Please check appropriate box.)*

☐ NEW If not a new applicant, check appropriate box and list affected policy number.

☐ **CHANGE/ADDITION TO AN EXISTING POLICY. POLICY #** _____

☐ Internal Replacement	☐ Conversion (over age dependent/divorce)
☐ Adding Dependents	☐ Policy/Benefit Change To An Existing Policy List Type of Change Requested: _____
☐ Adding a Spouse	☐ Reinstatement of Coverage

REQUESTED EFFECTIVE DATE

Requested effective date _____

A policy may not have an effective date of the 29th, 30th, or 31st. Your effective date is based on the date you sign your application form. Check with your agent for more details.

PERSONS TO BE INSURED

Attach a separate sheet, signed and dated, if additional space is needed.

	Name: Last	First	MI	Sex	Birthdate (MM/DD/YY)		
1. Proposed Insured							
2. Spouse							
3. Dependents *list relationship below*	Name: Last	First	MI	Sex	Birthdate (MM/DD/YY)	Full time student?	
Dependents *list relationship below*						☐ Yes ☐ No	
Dependents *list relationship below*						☐ Yes ☐ No	
Dependents *list relationship below*						☐ Yes ☐ No	
Dependents *list relationship below*						☐ Yes ☐ No	

4. Resident Address: _____
(No P.O. Boxes) (Street) (City) (State) (Zip)

5. Phone Number (with area code): _____ ☐ Home ☐ Business ☐ Cell

Please list the phone number that would be the best to reach you during the day for any inquiries.

FAX ALL PAGES EXCEPT "IMPORTANT NOTICES" TO 414-299-6020

6. Email Address: _____

7. Is the Proposed Insured a U.S. citizen or Lawful Permanent Resident/Green Card Holder? ..... ☐ Yes ☐ No

8. Is the Proposed Insured a dentist, dental hygienist, or employed in a dental office or clinic or as an insurance agent? ..... ☐ Yes ☐ No

9a. Proposed Insured Primary Occupation and Job Title : _____

Duties: _____

9b. Proposed Insured Primary Industry: _____ Standard Industrial Classification (SIC) code: _____

9c. Primary Employer's Name: _____

Employer's Phone Number: (_____) _____

Employer's Address: _____
(Street) (City) (State) (Zip)

Type of Business: _____

OTHER COVERAGE IN FORCE

10. Is the Proposed Insured covered by, or has application been made for any type of dental insurance? ..... ☐ Yes ☐ No

If 'Yes," complete the section below.

Insurance Company Name	Policy Number	Phone Number (include area code)	Effective Date (MM/DD/YY)	Is this coverage being replaced by proposed coverage?

EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT

You understand and agree that you are applying for dental insurance for you (and your family). You further understand this application for dental insurance is subject to eligibility requirements. You are personally paying the entire premium for this dental insurance coverage.

Your employer is not contributing in any way to the payment of premium, either directly or indirectly.

Do you agree with this statement? ..... ☐ Yes ☐ No

AUTHORIZATION

My application form, recorded Authorizations and any amendments shall be the basis for the contract.

The insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company. The effective date is assigned by Time Insurance Company. The premium must be paid when due. A change in the eligibility of the proposed insured(s) after the completion of the application form and before the delivery of the contract may affect my eligibility for insurance with the company. I understand and agree that any information I provide through this application process may be shared with persons necessary to facilitate issuing coverage, including but not limited to my agent or broker.

I understand that this authorization is required in order to enable Time Insurance Company to make eligibility or application determinations relating to me and/or my minor children. If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for insurance. I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization. Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: 30 days after denial of my application, or declination of application, or, if insured, 30 days after when I am no longer an insured of Time Insurance Company. But in no event will this authorization be in effect for longer than 24 months from the date signed.

I agree that a photocopy of this authorization shall be valid for two years from the date signed.

I acknowledge receiving the notification regarding the Abbreviated Notice of Insurance Information Practices and the Outline of Coverage for Health Insurance, if required.

I acknowledge that I have read the completed application form. I attest that all statements and answers on this application form are complete, true and correct. I understand and acknowledge that any fraudulent statement or material misrepresentation or omission on the application form, recorded Authorizations and/or any amendments may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provision of the contract.

_____	_____	_____ a.m./p.m.	_____	_____
Signature of Proposed Insured	Date Signed	Time Signed	City	State

Requested Effective Date: _____

Premium Amount Sent: $ _____

Attention: (Agent)
I have reviewed this application form to ensure that all required items have been completed.

I certify that:

☐ I personally saw the applicant. The applicant was asked each required question and the answer is truly and accurately recorded on the application in the respective response area. The answers are true to the best of my knowledge.

☐ The application was completed by the applicant or applicant's representative and the answers are true to the best of my knowledge.

_____
Licensed Resident Agent's Signature

_____
Print Agent's Name

_____ Initial here if you witnessed the signing of this form by the proposed insured.

FAX ALL PAGES EXCEPT "IMPORTANT NOTICES" TO 414-299-6020

IMPORTANT NOTICES – LEAVE WITH CUSTOMER

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.

FRAUD NOTICE

Any person who knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company may be guilty of insurance fraud as determined by a court of competent jurisdiction. 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 Division of Insurance within the Department of Regulatory Agencies.

PRIVACY

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on application forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.

BILLING

Complete the details below for the Primary applicant (PLEASE PRINT):

_____

Last Name First Name MI

You have four billing methods to choose from:

1. **Monthly payroll deduction (worksite billing)**

   ➜ Assigned account number, if known: _____

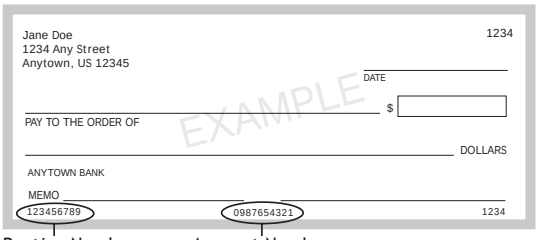
   Note to agent: this option requires the worksite to have 5 or more issued policies and a Worksite Billing Account Agreement Form on file.

2. **Electronic Funds Transfer (EFT)/Check-O-Matic** ➜ Choose how often: ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

   ➜ To begin EFT/Check-O-Matic withdrawals:
   Select a desired withdrawal day 1-28:_____

   Bank Name: _____
   City:_____ State:_____
   Routing number: _____ _____ _____ _____ _____ _____ _____ _____ _____
   Account number: _____

   ➜ To add this policy to an existing EFT/Check-O-Matic:
   Existing EFT/COM Number: _____
   Associated Policy Number: _____



Routing Number *9 digits* Account Number

AUTHORIZATION FOR EFT/CHECK-O-MATIC BILLING — please sign below
I (we) hereby authorize Time Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, indicated above, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Accountholder Signature: _____ Date: _____

3. **Credit card** ➜ Choose how often: ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

AUTHORIZATION FOR CREDIT CARD PAYMENTS — please sign below
I authorize Time Insurance Company to charge my account for the individual supplemental insurance policy.
I understand there will be no refund of premium after the 30-day free look in the contract

Card number: _____ _____ _____ _____ - _____ _____ _____ _____ - _____ _____ _____ _____ - _____ _____ _____ _____

Card type: ☐ VISA ☐ MasterCard

Expiration date: _____/_____

Name as it appears on card: _____

Cardholder billing address if different than resident address: _____

Cardholder signature: _____ Date:_____

4. **Bill me directly:** ➜ Choose how often: ☐ Quarterly ☐ Semi-Annual ☐ Annual

If your billing address is different than your home address, please enter it here:

Billing Address: _____
(Street) (City) (State) (ZIP)

Name of person paying, if different:_____