

Short Term Medical Instructions

Instructions for filling out the Short Term Medical Insurance form:

- "Certificate/Policy Number" please leave blank and we will fill out when received.
- "Requested effective date" please leave blank and we will fill out when received.
- "Payment information" can be done by you or your parents and submitted to Assurant Health directly. If you wish we can bill your student account. Any forms with payment information left blank will be processed through our student finance office.
- Fill out the rest of the form in its entirety and sent to PUC Health Services. Please note that the deductible is \$1,000.00. PUC may be available to assist you in paying your deductible only if you are seen and screened by the health services department PRIOR to accessing medical care. This will be determined on a case-by-case basis.
- This policy is for 6 months and will be automatically renewed unless our office is contacted prior to renewal date. To find your enrollment date please refer to your insurance card or contact Health Services at (707) 965-6339 or our broker Jim Aldred (707) 477-2107.

Assurant Health is the brand name for products underwritten and issued by John Alden Life Insurance Company. Please access www.assuranthealth.com or call (800) 800-5453 for additional information.

Please note that any false or inaccurate information or misrepresentation on this enrollment form may result in claim denial or contract rescission. Any fraudulent information deems the individual guilty of a felony in the third degree and any charges paid will then become the responsibility of the individual at the total cost of usual and customary charges.

Short Term Medical Enrollment Form **John Alden Life Insurance Company** **CALIFORNIA**

REQUESTED EFFECTIVE DATE			Note: Effective date is assigned by John Alden Life Insurance Company. The effective date is the later of: 1. The day after: a) the date this form is signed; b) the date this form is postmarked for mailing to John Alden Life Insurance Company; or c) the date we receive your enrollment request by electronic transmission in our home office, OR 2. If dates cannot be determined, the day we receive this form by mail. The agent cannot assign an effective date different than this.	CERTIFICATE/POLICY NUMBER
MONTH	DAY	YEAR		

APPLICANT'S NAME (Print last, first, middle)			GENDER	BIRTH DATE	SOCIAL SECURITY NUMBER
STREET ADDRESS			CITY, STATE, ZIP CODE		
SPOUSE'S NAME (if to be insured)			GENDER	BIRTH DATE	SOCIAL SECURITY NUMBER
CHILDREN'S NAME (if to be insured) 1.	BIRTH DATE	NAME 2.	BIRTH DATE	NAME 3.	BIRTH DATE

NOTE: The plan cannot be issued if YES is answered to any questions 1 through 4. Under no circumstances can coverage become effective prior to the date this application is signed.

California law prohibits an HIV test from being required or used by health care plans as a condition of obtaining coverage.

Answer the following questions completely and accurately.

	YES	NO
1. Have/Are you, your spouse, or any person to be insured:	<input type="checkbox"/>	<input type="checkbox"/>
◆ now pregnant, an expectant parent, in the process of adopting a child or undergoing infertility treatment? ◆ over 300 pounds if male, or over 250 pounds if female?		
2. In the past 15 days have you or any person to be insured: been seen by a healthcare professional for any reason other than a routine checkup or been admitted to a hospital?	<input type="checkbox"/>	<input type="checkbox"/>
3. In the past 12 months, have you or any person to be insured: been recommended to have or been scheduled for diagnostic testing, treatment or surgery that has not been completed?	<input type="checkbox"/>	<input type="checkbox"/>
4. For any of the following conditions within the last 5 years, have you or any person to be insured received any abnormal test results or medical or surgical treatment, or consulted a health care professional, or taken medication for:	<input type="checkbox"/>	<input type="checkbox"/>
◆ heart disorder including but not limited to heart attack or chest pain? ◆ AIDS/ARC excluding abnormal test results for HIV status? ◆ diabetes? ◆ Emphysema? ◆ stroke? ◆ cancer or tumor? ◆ Crohn's disease, ulcerative colitis or hepatitis? ◆ kidney disorder, excluding kidney stones? ◆ alcoholism, chemical dependency, drug or alcohol abuse?		

DEDUCTIBLE AMOUNT	PAYMENT OPTION AND LENGTH OF COVERAGE	RATE OF PAYMENT	TOTAL
<input type="checkbox"/> \$ 500 <input checked="" type="checkbox"/> \$ 1,000 <input type="checkbox"/> \$ 2,500	<input type="checkbox"/> Single Payment - Total number of months needed <u>6</u> <input checked="" type="checkbox"/> Monthly Payment - Coverage is needed for: up to 6 months (30-180 days)	<input type="checkbox"/> 80%	

Please provide the name, address, phone number and policy number for each health insurance policy you had during the previous 12 months.

NAME	ADDRESS	TELEPHONE NUMBER	POLICY NUMBER
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The undersigned attests that the information above is true to the best of his/her knowledge. The undersigned realizes that any false, or inaccurate statement or misrepresentation in the enrollment form may result in claim denial or contract rescission. Any person who injures, defrauds, or deceives any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. The undersigned understands that the plan applied for will not pay benefits for any expenses incurred on account of any condition which manifested itself before the effective date. If I am self employed or an employee of an employer with 50 or fewer employees, I warrant premiums for this coverage are not: (1) Paid or reimbursed by my employer or, (2) To the best of my knowledge, treated as tax-deductible by my employer or me as related to an employer benefit plan (Internal Revenue Code sections 106,125,162 or 213).

WE RELY EXCLUSIVELY ON THE ANSWERS YOU HAVE PROVIDED. WE WILL NOT VERIFY THE ACCURACY OR COMPLETENESS OF YOUR ANSWERS PRIOR TO ISSUING COVERAGE. IF YOUR ANSWERS ARE NOT ACCURATE AND COMPLETE, YOUR COVERAGE WILL BE RESCINDED (TERMINATED AS OF THE EFFECTIVE DATE) AND NO CLAIMS WILL BE PAID.

PRIMARY PHYSICIAN'S NAME (IF ANY)	PRIMARY PHYSICIAN'S TELEPHONE NUMBER
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APPLICANT'S SIGNATURE	TODAY'S DATE
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DAY TELEPHONE NUMBER	EVENING TELEPHONE NUMBER
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FORM JT-1147.CA (Rev. 4/2008)

Electronic Policy Option

I would like to receive my policy and the company's "Notice of Privacy Practice" via the Internet. Yes No EMAIL ADDRESS

To receive policy delivery via the Internet, you must provide your email address in the space to the right. ➡

Payment Information

Step 1: Select a Method of Payment: MasterCard Visa Check Automatic charge to checking account (Only available with the Monthly Payment Option)

Please submit first month premium via check along with a separate voided check.

Important Reminders: The application fee is non-refundable. There will be no refund of premium after the 10-day free look period in the contract.

Step 2: Authorization

◆ When selecting the single payment option with MasterCard/Visa: I authorize Assurant Health to charge my account for the Short Term Medical policy listed above.

◆ When selecting the monthly payment option with MasterCard/Visa or Automatic Charge to a checking account: I authorize Assurant Health to charge my account each month for the Short Term Medical policy listed above, until the end of the policy or until I request cancellation in writing. I understand I can request the charge be stopped if I notify Assurant Health seven days in advance of the charge occurring.

Card # --- Exp. Date: ____ / ____ Authorized Amount \$ _____ (Insert Initial Premium Payment Amount)

ACCOUNT HOLDER'S SIGNATURE	DATE	APP SOURCE
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JOHN ALDEN AGENT NAME & ID #	NORTH STAR MARKETING REP NAME	CONFIRMATION CODE (HOME OFFICE USE ONLY)
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