

Medical Savings Insurance Application Check List

- All Medical questions must be answered, if any are answered yes, please give complete details, including Physicians name and address.
- Make sure that all applications are signed and dated. (especially on the back side of application)
- If paying via monthly Bank Draft, please also complete Bank Authorization, and attach a voided check.

You can fax your completed Application back to **(803)781-7750**

Or Mail to the following address:

Health Benefits ABC
Attn: David Greenhalgh
PO Box 186
Ballentine, SC 29002

FAX: (803) 781-7750

Please feel Free to call us at any time with additional questions
(800) 861-3834

Plan #1

#1

- ✓ Keeps insurance costs down
- ✓ Choose your own physician
- ✓ Only one deductible per family
- ✓ Health Savings Account (Qualified HSA)
- ✓ Protects your assets from big major medical expenses

Most of the cost of insurance comes from tons of small claims. The cost of this plan is kept down by having you handle the smaller health care bills yourself. We pay the bigger bills...up to **TWO MILLION DOLLARS PER FAMILY MEMBER.**

PLAN OUTLINE

- \$2,000,000 lifetime major medical protection per person.
- Deductibles – You choose:
Individuals: \$1,000, \$1,700 or \$2,600.
Family (Individual & 1 Dependent): \$2,000, \$3,450 or \$5,150.
- After the deductible is satisfied, if there is a secondary illness or injury, there are limited copayments capped at \$500.00.
Doctor office visit: \$15.00; Diagnostic test (X-ray, etc.): \$20.00;
Prescription drugs: \$15.00; Inpatient hospital: \$250.00;
Outpatient surgery: \$200.00.
- Choose your own physician.
- Nurseline for precertification.

PLAN #1 BENEFITS -- BIG MEDICAL BILLS PAID BY THE INSURANCE COMPANY:

- Daily hospital room and board at network or most common semiprivate rate.
- Surgery in an outpatient surgical center.
- Professional fees of doctors and surgeons (but not for standby availability).
- Local ambulance service to a hospital for necessary emergency care.
- Hospital emergency treatment of an injury.
- Dressings, sutures, casts, or other necessary medical supplies.
- Artificial limbs, eyes, larynx, or breast prosthesis.
- Professional services of a licensed physiotherapist.
- Hemodialysis, processing and administration of blood components.
- Charges for an operating, treatment, or recovery room for surgery.
- Dental expenses due to an injury that damages natural teeth if expenses are incurred within 6 months of injury.
- Surgical treatment of TMJ disorders.

- Cost and administration of an anesthetic, oxygen and other gases.
- Radiation therapy or chemotherapy.
- Prescription drugs.
- Diagnostic testing using radiologic, ultrasonographic or laboratory services.
- Home health care.
- Hospice care.
- Well care benefits as set forth in the policy.
- Complications of pregnancy.

DETERMINATION OF REASONABLE AND CUSTOMARY CHARGES

Medical Savings Insurance Company provides benefits for the *reasonable and customary charge of covered expenses*, as defined by our contracts of insurance. In determining whether a charge is reasonable, we may consider a number of factors. Those factors are described in our contracts and may include federal Medicare diagnostic codes and reimbursement rates, with appropriate markups to reflect national average payment reimbursement rates for services, medicines, or supplies.

TRANSPLANT EXPENSE BENEFITS

The following types of transplants are covered expenses, subject to all policy provisions, including Exclusions and Limitations:

Category 1

Cornea transplants
Artery or vein grafts
Heart valve grafts
Prosthetic tissue & joint replacement
Prosthetic lenses for cataracts

Category 2

(Coverage limited to \$100,000)
Heart
Heart/Lung
Kidney
Liver
Bone marrow

PRECERTIFICATION AND UTILIZATION REVIEW

All admissions, surgical procedures, and home health care must be precertified as efficient and necessary. When appropriate, precertification will be given by a specially trained independent utilization reviewer.

You are required to contact the reviewer for precertification. The reviewer will advise you when the treatment is precertified. Failure to obtain precertification will result in a reduction in benefits. Precertification is not a guarantee of benefits or payment.

PREEXISTING CONDITIONS

A preexisting condition is an injury or illness for which medical advice, diagnosis, care or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 6 or 12 months immediately preceding the effective date of coverage. We will not pay any benefits for loss due to a preexisting condition or a natural progression of a preexisting condition, unless the covered person's preexisting condition was fully disclosed to us on the person's application for insurance under this policy and we agreed to issue coverage. See policy certificate for details.

LIMITATIONS AND EXCLUSIONS

No benefits are payable for expenses, services, or supplies:

- Which cost more than what was determined by us to be the reasonable and customary charge for a service or supply.
- That would be provided without cost in the absence of insurance covering the charge.
- Performed by a member of a covered person's immediate family.
- Unless administered or ordered by a doctor and medically necessary to the diagnosis or treatment of an injury or illness.
- Not actually provided while the policy is in force.
- Resulting from (1) a self-inflicted injury; (2) any act of declared or undeclared war; or (3) taking part in a riot or the commission of a felony.
- For injuries or illnesses arising out of, or in the course of, employment for wage or profit (unless the covered person is the business owner and benefits are not payable under Workman's Compensation).
- Incurred while confined mainly for custodial, educational, or rehabilitative care or nursing services (unless expressly provided for by the policy).
- Incurred for cosmetic or aesthetic reasons, weight modification, surgical treatment of obesity, or breast reduction or augmentation.
- For modification of the physical body in order to improve psychological, mental or emotional well-being of the covered person, including sex-change surgery.
- For dental expenses (unless expressly provided for by the policy).
- For vocational or recreational therapy or rehabilitation.
- Charges for an assistant surgeon are covered up to 20 percent of what we determine to be the primary surgeon's reasonable and customary charge.
- After the deductible is satisfied, if there is a secondary illness or injury, there are limited copayments capped at \$500.00. Doctor office visit: \$15.00; Diagnostic test (X-ray, etc.): \$20.00; Prescription drugs: \$15.00; Inpatient hospital: \$250.00; Outpatient surgery: \$200.00.

- For any drug, treatment or procedure that either promotes or prevents conception or prevents childbirth such as artificial insemination, treatment for infertility or impotency, sterilization or reversal of sterilization, or abortion (unless the life of the mother would be endangered if the fetus were carried to term).
- For non-surgical treatment of disorders of the temporomandibular joint.
- For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or any examination or fitting related to these devices.
- Due to pregnancy or for routine well-baby care of a newborn infant, unless expressly provided for in the plan.
- For preventive care (unless specifically provided for in the policy).
- For television, telephone, or expenses for other persons.
- For marriage, family, or child counseling or for the treatment of premarital, marriage, family, or child relationship dysfunctions.
- Related to a procedure or treatment which is investigational, experimental, or for research.
- For eye surgery to correct nearsightedness, farsightedness, or astigmatism.
- For substance abuse.
- For mental or nervous disorders.
- For treatment provided in a government hospital.
- For services paid for under Medicare or other governmental programs, except Medicaid.
- For services paid for under any state or federal workman's compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law.
- There are additional limits for physical therapy, air ambulance and transplants stated in the policy.

Exclusions and limitations are more fully set forth in the policy and certificates. Refer to the policy statements for specific information regarding coverages, limitations and exclusions.

All admissions, surgical procedures, and home health care must be precertified as efficient and necessary.



MEDICAL SAVINGS

HEALTH PLAN

5835 West 74th Street • P.O. Box 68961
 Indianapolis, IN 46268-0961
 Phone: (317) 329-8222, Fax: (317) 329-3080

APPLICATION FOR INSURANCE

Please print with black ink.

To be personally completed by the proposed insured.

Requested effective date of insurance: _____

COVERAGE INFORMATION

Applicant's first name	Last Name	Social Security No.	Sex	Birthdate	Height	Weight
Joint Applicant's first name	Last Name	Social Security No.	Sex	Birthdate	Height	Weight
Street Address or P.O. Box			Home Phone (with area code)		Work Phone (with area code)	
City, State, and ZIP Code						

DEPENDENT CHILDREN TO BE COVERED (attach separate paper for more space)

First Name	Last Name	Sex	Birthdate	Height	Weight



INCOME

Under \$15,000
 \$15,001–\$25,000
 \$25,001–\$35,000
 \$100,000 or more
 \$35,001–\$50,000
 \$50,001–\$75,000
 \$75,001–\$99,999
 Occupation: _____

APPLICANT'S BENEFICIARY

(Give full name, relation to you, and age.)
 (Applicant will be the beneficiary for all other persons, if applicable.) _____

HEALTH PLAN CHOICES

Choose your plan: <input type="checkbox"/> Plan #1 <input type="checkbox"/> Plan #2 <input type="checkbox"/> Plan #3		Choose your deductible: <input type="checkbox"/> Family \$2,000 <input type="checkbox"/> Husband and Wife \$2,000 <input type="checkbox"/> Parent and Child(ren) \$2,000 <input type="checkbox"/> Family \$3,450 <input type="checkbox"/> Husband and Wife \$3,450 <input type="checkbox"/> Parent and Child(ren) \$3,450 <input type="checkbox"/> Family \$5,150 <input type="checkbox"/> Husband and Wife \$5,150 <input type="checkbox"/> Parent and Child(ren) \$5,150 <input type="checkbox"/> Single \$1,000 <input type="checkbox"/> Single \$1,700 <input type="checkbox"/> Single \$2,600		Choose your HSA deposit: \$_____ (monthly deposit) (maximum \$166.66 per month \$2,000 per year) \$_____ (monthly deposit) (maximum \$287.50 per month \$3,450 per year) \$_____ (monthly deposit) (maximum \$429.16 per month \$5,150 per year) \$_____ (monthly deposit) (maximum \$83.33 per month \$1,000 per year) \$_____ (monthly deposit) (maximum \$141.66 per month \$1,700 per year) \$_____ (monthly deposit) (maximum \$216.66 per month \$2,600 per year)
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Optional: <input type="checkbox"/> If I do not qualify for Plan #1 or Plan #3, I still would like Plan #2.	Optional: <input type="checkbox"/> Hospital Indemnity Rider (a one-time charge of \$65.)	Health Insurance Premium: \$ _____ Monthly HSA Deposit: \$ _____ Administration Fee: \$ _____ 9.90
Optional: <input type="checkbox"/> Term Life Rider Monthly Rate: \$ _____	I prefer to pay: <input type="checkbox"/> Monthly by Preauthorized Check <input type="checkbox"/> Quarterly Direct Bill	Options: Hospital Indemnity Rider: \$ _____ Term Life Rider: \$ _____ Total: \$ _____

No application will be accepted if received by Medical Savings Insurance Company more than 15 days after the date signed.
 ALTERED APPLICATIONS WILL NOT BE ACCEPTED.

PRIOR COVERAGE QUESTIONS

Are any applicants covered by, or have they been covered by, health insurance in the last 6 months? Yes No
(If Medical Savings Insurance Company issues coverage, it will not take effect until any previous health insurance is no longer in force.)

Has any applicant ever applied for, or been covered by, Medical Savings Insurance Company? Yes No

HEALTH QUESTIONS

1. Has any applicant smoked cigarettes or used: chewing tobacco ; snuff ; a pipe ; or a cigar within the last 12 months? Who: Yes No

2. In the past 5 years, has any applicant taken part in flying as a pilot, parachuting, hang gliding, under-water diving, auto racing, or driving or riding as a passenger on any type of motorcycle; or does any applicant expect to take part in any of these activities in the next 2 years? If YES, specify who and which activities: Yes No

3. Is any applicant currently:
a. a user of alcoholic beverages in excess of 14 drinks per week: (one drink equals: 12 oz. of beer; 5 oz. of wine; 1 oz. of hard liquor)? If yes, show who and how many drinks per week: ____
..... Yes No

b. taking medication or receiving medical treatment of any kind? (Describe under Health Details on the last page.) Yes No

4. Is any applicant or family member (whether or not listed on the application) an expectant parent or currently pregnant? If yes, give expectant parent's name (mother/father): Yes No

5. Does any applicant or family member have a history of pregnancy complications, or Caesarean Section delivery? Yes No

If any answer to questions 6-12 is YES, provide all details in the "Health Details" section on the last page.

6. Has any applicant gained or lost 15 pounds or more within the last 12 months? Yes No

7. Has any life or health insurance application or policy on any applicant ever been voided, declined, canceled, postponed, or modified as to plan, amount, or rate? Yes No

8. Has any applicant within the last 10 years had any indication, diagnosis, or treatment of any disease or disorder of the:

a. heart or circulatory system, including, but not limited to high blood pressure, anemia, heart attack, heart murmur, chest pain, irregular heartbeat, varicose veins, phlebitis, or stroke? Yes No

b. nervous system, including, but not limited to epilepsy, seizures, convulsions, headaches, or paralysis? Yes No

c. digestive system, including, but not limited to ulcer, gastritis, intestinal disorders, colitis, hemorrhoids, bloody stools, or hernia, or of the esophagus, liver, pancreas, spleen, or gallbladder? Yes No

d. muscular or skeletal systems, including, but not limited to arthritis, gout, or any jaw, knee, back, joint or spine disorder, or deformity? Yes No

e. lungs or respiratory system, including, but not limited to allergies, asthma, bronchitis, tuberculosis, pneumonia, or emphysema? Yes No

f. bladder, kidney, or genito-urinary system, including, but not limited to urinary tract infections or blood in the urine? Yes No

g. male or female reproductive organs, prostate problems, irregular menstruation, or abnormal pap test? ... Yes No

h. eyes, ears, nose, mouth, or throat, such as double vision, ear infection, deviated nasal septum, thrush, or tonsillitis? Yes No

9. Has any applicant within the past 10 years had any indication, diagnosis, or treatment of:
a. tumor, cyst, polyp, or growth of any kind? Yes No

b. skin disorder or disease? Yes No

REQUEST FOR PREAUTHORIZED CHARGE PLAN

Medical Savings Insurance Company (M.S.I.C.) is hereby requested and authorized to present charges drawn on my checking account number _____ beginning on or about the _____ day of each month thereafter until this authorization is revoked.

charge. I agree that your treatment of each such charge and your rights with respect to it shall be the same as if a check were signed personally by me. I further agree that if any such charge is dishonored, whether with or without cause, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

I understand that all advance premiums will be refunded to me if coverage is not issued and that the effective date of my insurance will be the date stated in my plan of coverage.

(Note: Your signature below the bank authorization portion will also apply to the above authorization.)

(IMPORTANT: BE SURE TO INCLUDE A VOIDED BLANK CHECK OR A BLANK DEPOSIT SLIP FOR YOUR BANK CHECKING ACCOUNT WITH THIS AUTHORIZATION.)

Medical Savings Insurance Company is instructed to forward authorization to you.

X _____ Date

X _____ SIGNATURE OF BANK DEPOSITOR - AS SHOWN ON BANK RECORDS FOR THE ACCOUNT TO WHICH THIS AUTHORIZATION IS APPLICABLE

Print the name and address of your bank.

Bank _____

Address _____

City _____ State _____ Zip _____

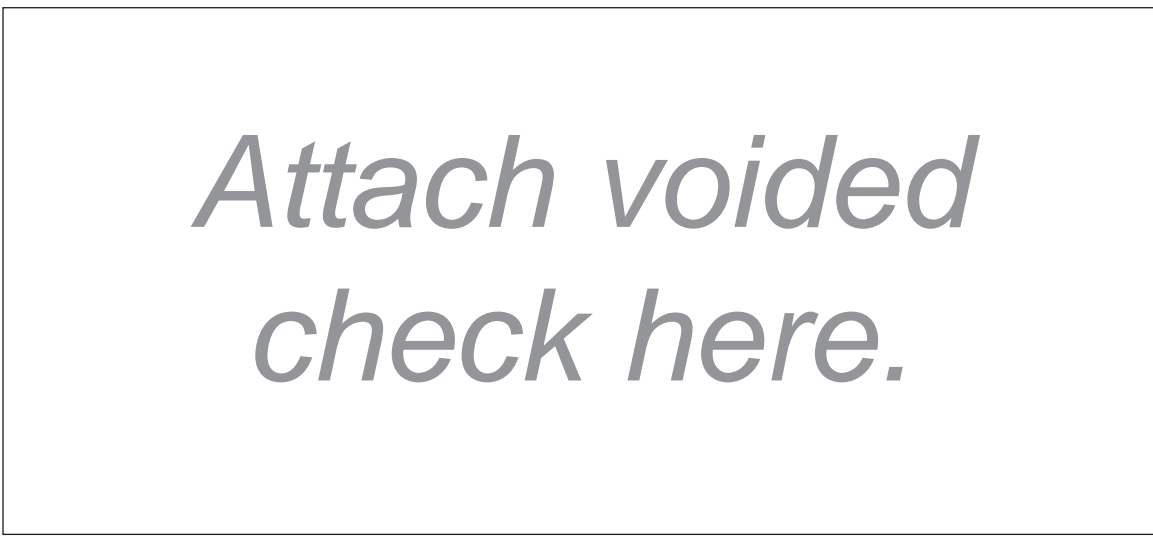
_____ Checking Account Number

_____ Printed Name of Bank Depositor

Authorization to Honor Charges Drawn in the Name of M.S.I.C. As a convenience to me, the undersigned, I authorize you to pay and charge to my account association dues, premium drawn on my account in the name of M.S.I.C. by check, electronic debit, or otherwise. This authorization will remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring such

_____ Name of Bank and Branch Name (if any)

_____ Transit No.



AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I (we) authorize Medical Savings Insurance Company (M.S.I.C.), its reinsurers, and their authorized representatives to obtain information they need to underwrite or verify my application or claim for life or health insurance. Any person having any information as to a diagnosis, the treatment or prognosis of any physical or mental conditions of me or my family and any nonmedical information about me or my family is authorized to give it to the above parties. This includes information related to substance use or abuse. Any doctor or other medical practitioner, hospital, clinic, medical facility, pharmacy, the Veterans Administration, the Medical Information Bureau (MIB), employer, or insurance company that may have such information is authorized to give this information to M.S.I.C.

M.S.I.C. may also release this information about me or my family to its reinsurer, to the MIB or to another insurance company to whom (we) apply for insurance or request benefits.

This authorization shall remain valid for 30 months from the date shown below. A photocopy of this authorization is as valid as the original. I (we) may obtain a copy by writing to M.S.I.C.

X _____ Date X _____ Signature of Proposed Insured (You) X _____ Signature of Spouse if to be insured

THE BROKER MUST ALWAYS COLLECT THE INITIAL PREMIUM AND COMPLETE THIS CONDITIONAL RECEIPT.

CONDITIONAL RECEIPT FOR _____

Proposed Insured: _____

Amount Received: _____ Date of Receipt: _____

NO INSURANCE WILL BECOME EFFECTIVE UNLESS EACH AND EVERY CONDITION CONTAINED IN THIS RECEIPT IS MET. NO AGENT OR BROKER IS AUTHORIZED TO ALTER OR WAIVE ANY OF THE FOLLOWING CONDITIONS.

Subject to the limitations shown below, insurance will become effective under this receipt if the following conditions are met:

1. The application is completed in full and is unconditionally accepted and approved by Medical Savings Insurance (M.S.I.) at its Executive Office.
2. The person is a member of an approved association.
3. All medical examinations, if required, have been *satisfactorily completed*.
4. The persons proposed for insurance must be, on the *effective date for injuries*, not less than a standard risk acceptable to M.S.I. according to its regular underwriting rules and standards for the exact plan and amount of insurance applied for.
5. The first full premium, according to the mode of premium payment chosen, has been paid on or prior to the *effective date for injuries*, and the check is honored on first presentation for payment.
6. The certificate is: (a) issued by M.S.I. exactly as applied for within 45 days from date of application; (b) delivered to the proposed insured; and (c) accepted by the proposed insured.

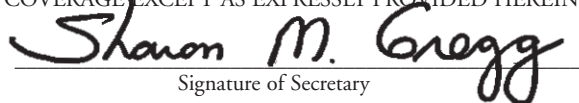
Definitions:

1. "*Satisfactorily completed*" means that no adverse medical conditions or abnormal findings have been detected which would lead Medical Savings Insurance to decline issuing the certificate or to issue a specially ridered certificate.
2. "*Effective date for injuries*" means the later of: (a) the requested effective date, if any, shown on the application; or (b) the first day of the month following the date received by M.S.I. at its Executive Office.
3. "*Effective date for illnesses*" means the 15th day after the effective date for injuries.

Limitation:

If, for any reason, M.S.I. declines to issue a certificate or issues a certificate other than a standard certificate as applied for, M.S.I. shall incur no liability under this receipt except to return any premium amount received. Interest will not be paid on premium refunds.

THIS CONDITIONAL RECEIPT DOES NOT CREATE ANY TEMPORARY OR INTERIM INSURANCE AND DOES NOT PROVIDE ANY COVERAGE EXCEPT AS EXPRESSLY PROVIDED HEREIN.


Signature of Secretary

Printed Name

Signature of Agent/Broker

59529-9816

Producer No.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO MEDICAL SAVINGS INSURANCE. DO NOT PAY CASH OR MAKE CHECKS PAYABLE TO THE AGENT OR BROKER OR LEAVE THE PAYEE BLANK.

If you do not hear from M.S.I. regarding the proposed insurance within 30 days, notify us, giving the name of the agent or broker, the date, and the amount paid.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

If you intend to lapse or otherwise terminate existing insurance and replace it with a new plan from M.S.I. you should be aware of and seriously consider certain factors that may affect your coverage under the new plan.

1. Health conditions that you now have may not be immediately or fully covered under the new plan. This could result in a claim for benefits being denied, reduced, or delayed under the new plan, whereas a similar claim might have been payable under your present plan.
2. If after due consideration, you still wish to terminate your present insurance and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical

information or correct information regarding the tobacco use of any applicant may cause the Company to deny a future claim and to void your coverage as though it had never been in force. After you have completed the application and before you sign it, reread it carefully. Be certain that all information has been properly recorded.

3. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of, or addition to, your present plan. You should be certain that you understand all the relevant factors involved in replacing or adding your present coverage.
4. Finally, we recommend that you not terminate your present plan until you are certain that your application for the new plan has been accepted by M.S.I.

MSA ASSOCIATION
MEMBERSHIP ENROLLMENT FORM

The MSA Plan is a group plan for
Association members

The MSA Plan is a group plan for
Association members

I hereby apply for membership in Citizens for a Sound Economy (CSE), and understand that I will be entitled to CSE's benefits. I understand that my membership will become effective on the day this Enrollment Form is dated and signed. I also understand that CSE benefits are subject to change, according to availability and at the discretion of CSE and/or the benefit providers, and that, promptly upon request, a Membership Kit will be sent to me telling me in detail what benefits are currently available. I also understand that I am eligible to apply for insurance upon completion of this Enrollment Form and payment of the initial dues to CSE.

Name: _____ Date of Birth: ____/____/____
PRINT First Name Middle Initial Last Name Month/Day/Year

Address: _____

City: _____ State: _____ Zip Code: _____ Telephone Number: (____) _____

Member's Signature X _____ Date _____



Citizens for a Sound Economy (CSE) members know that government goes to those who show up. For the past 16 years, CSE has identified, and educated citizens who support free enterprise and limited government.

What we do:

CSE recruits and educates volunteers to fight for less government, lower taxes and more freedom.

Why we do it:

CSE believes in individual liberty, the freedom to compete, expanding consumer choices and providing individuals with the greatest control over what they own and earn.

How we do it:

CSE's campaigns educate a growing volunteer grassroots group to vote for policy change.

CSE: We make good policy good politics.

1250 H Street, NW, Suite 700, Washington, DC 20005

• 888-JOIN-CSE • 202-783-4687 • www.cse.org