



Apply Now

- When completing the health history application, try to answer all medical questions with as much detail as possible. Don't worry about leaving anything blank – we will review your application upon receipt and let you know if you missed anything.
- Keep in mind the underwriting process can take up to six weeks. If the underwriter requests medical records, the decision could take longer (up to 60 days). If you need coverage right away, call us or visit our website to sign up for short-term medical insurance (coverage can start as early as midnight tonight).
- Please review the following chart for payment details:

	MEDICA	MCHA	BLUE CROSS	HEALTH PARTNERS
1 st Month's Premium required with application	✓	✓	✓	
Automatic withdrawal required for monthly payment	✓	✓	✓	✓

**Checks must be written from a personal account; however, there are exceptions to this rule. Please contact an InsuranceSmart representative for details. All checks are payable to the insurance carrier NOT InsuranceSmart.*

- Sign and date application. Applications must be received by the home office of the insurance company within 15 days of the signature date.
- Return the application to:

InsuranceSmart

9220 Bass Lake Rd, Suite 300

New Hope, MN 55428

Fax 763-577-0358 (HealthPartners applications may be received via fax)

We will send a confirmation notice upon receipt of your application. Do not cancel your existing medical policy until you have verification that your new policy has been approved. Should you be declined coverage, you may qualify for the Minnesota Comprehensive Health Association (MCHA) Plan. Please contact an InsuranceSmart representative for more details.

We look forward to servicing your insurance needs. Please don't hesitate to contact us at 763-550-0638 or 800-645-6920 with any questions or concerns you may have.



9220 Bass Lake Road, Ste 300 – New Hope, MN 55428

763-550-0638 or 800-645-6920 Fax 763-577-0358

www.InsuranceSmartOnline.com ■ MN Lic #IA-20018362



PREFERREDONE INSURANCE COMPANY (PIC) INDIVIDUAL INSURANCE APPLICATION FORM

This plan is intended to qualify as a high deductible health plan that may be paired with a Health Savings Account (HSA), however, you should check with your tax advisor for guidance with your particular situation.

Enrollment Form Instructions. Please use ink when filling out a paper application.

1. Please review your application to assure that every question has been answered completely.
2. The health questions pertain to all applicants. To avoid unnecessary delays, please provide a complete explanation of all "yes" answers. When completing a paper application attach a separate sheet if additional space is needed. Please indicate whether any checkups, physicals, exams, lab work, or x-rays you have listed were routine or due to symptoms of illness or injury. Also, indicate if the results were normal or if any problems were noted. For each medical condition, illness, or injury, include the onset date and the complete recovery date where applicable.
3. Indicate if you are opting out of chemical dependency coverage. You are only eligible for this option upon initial enrollment.
4. Payment Instructions

Paper Application: You are required to submit a separate **NON-REFUNDABLE** \$20.00 check payable to PIC in order for the application to be processed.

In addition to the non-refundable application fee, a separate check for the estimated first month premium is due at time of application. If your effective date is after the 1st of the month, the prorated partial month premium based on the number of days of coverage for that month plus one full month's premium is due. Refer to the rate table for rates.

You are also required to complete the Electronic Payment Plan (EPP) form attached to the enrollment form. PIC will draw from your account your monthly premium on or near the 8th of each month, starting with your second full month's coverage.

Online Application: You are required to submit a **NON-REFUNDABLE** \$20.00 application fee payment via credit card.

You will be required to complete the Electronic Payment Plan (EPP) form and PIC will draw from your account your monthly premium on or near the 8th of each month.

5. Please complete, sign and date your application. All adults, including dependent children age 18 and over, must sign. A parent or legal guardian must sign for dependent only coverage. PIC must receive your enrollment form within 10 days of the signature date or it will be returned to you. Applications are valid for 60 days from the signature date. After 60 days a new application must be completed in full.
6. Make a copy of the application for your records. Fold and mail the application to PIC at the address below or in the enclosed postage prepaid envelope.
7. You will be required to sign up for auto-pay and PIC will draw from your account on or near the 8th of each month.
8. PIC will notify you as to whether you have been approved and your effective date. Approved applicants will receive an effective date of any date between the 1st and the 28th of the month. Your effective date will automatically be reset to the first of that second month, and your contract will renew each year on the first of that month. Processing time of your application is approximately 3-4 weeks depending on the completeness of your application. **No existing coverage should be cancelled until written notice of approval of this application is received.**
9. PIC may require medical records to complete the underwriting process. If a request for medical records is required, PIC will pay up to \$25 to obtain them.

Providing false information on the application may result in the denial of claims or rescission of coverage. Please review your application to ensure its accuracy.

P.O. Box 59212 | Minneapolis MN 55459-0212
763.847.4477 1.800.997.1750
www.preferredone.com

Applicants Name: _____

Date: _____

ELIGIBILITY REVIEW FORM

COMPLETE THIS FORM AND RETURN WITH YOUR APPLICATION

The following is a guideline to determine eligibility. The applicant may not be eligible or qualify for coverage if any of the following applies:

The applicant and/or any person to be insured currently has or has had in the past one or more of the ineligible medical conditions.

(see ineligible conditions list)

Y / N

The applicant and/or any person to be insured is over the acceptable height/weight limits. **(see weight chart)**

Y / N

The applicant and/or any person to be insured are employed in an ineligible occupation. **(see ineligible occupation list)**

Y / N

The applicant and/or any person to be insured are currently pregnant or an expectant parent.

Y / N

(The parents or child/children are not eligible for coverage until six months after the date of discharge from the hospital. Pregnancy is not a covered expense for the first eighteen months of the contract.)

The applicant and/or any person to be insured is under 6 months of age.

Y / N

The applicant and/or any person to be insured has:

- (1) a pending doctor's appointment (other than routine),
- (2) scheduled treatment or diagnostic testing,
- (3) recommended or scheduled surgery.

Y / N

(Ineligible applicants are those with non-routine appointments, diagnostic testing, treatment or surgery. These applicants should postpone applying until after the appointment, treatment or surgery is complete and the results and diagnoses are known.)

The applicant and/or any person to be insured are not U.S. citizens, immigrants on visa status and have not been in the U.S. for one year or more.

Y / N

The applicant and/or person to be insured has plans for extended travel (extended travel is defined as three months or more, this includes students who travel abroad or study overseas).

Y / N

The applicant and/or any person to be insured age 50 or older has not had a physical within the last three years.

Y / N

The applicant and/or any person to be insured is eligible for Medicare.

Y / N

The applicant and/or any person to be insured has had bariatric surgery in the past four years.

Y / N

NOTE: Subject to change at any time without notice. Coverage to be provided or denied only after review of an individual application properly submitted to PreferredOne.



OFFICE USE ONLY	
Underwriting Approval _____	Chemical Dependency Rider _____
Effective Date _____	Application/Contract # _____
Product _____	
Plan I.D. _____ Area: _____	

Premium amount sent: \$ _____ (Separate Check) for one-time application processing fee: \$20.00

Agent Information

Agent Name Ron Grams Jr.	Agent # 11702	General Agent #
------------------------------------	-------------------------	-----------------

Member Information

Last Name (Legal Name)	First Name	MI	Date of Birth	Social Security Number
Street Address/Apt. No.		City		State Zip
E-mail Address			Height	Weight
			<input type="checkbox"/> Married	<input type="checkbox"/> Male
			<input type="checkbox"/> Single	<input type="checkbox"/> Female
Telephone Number: Home		Telephone Number: Work		Telephone Number: Cell
Occupation Applicant		Occupation Spouse		Requested Effective Date

Fill in the following information for each person requesting coverage, starting with yourself

LAST NAME ONLY IF DIFFERENT FROM ABOVE	FIRST NAME	M.I.	RELATIONSHIP	SEX (M or F)	DATE OF BIRTH	Ht	Wt	SOCIAL SECURITY NO.	INTERNAL USE ONLY RATE TABLE
			Self		Month Day Year				

If last name is different for dependents, please explain why:
Other than your spouse, are any of the above listed dependent(s) age 25 or older? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, list name(s)
Other than your spouse, are any of the above listed dependent(s) married? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, list name(s)
I request coverage for: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Children

Chemical Dependency Related Disorders: I want to include at an additional cost, benefits for the diagnosis and treatment of chemical dependency related disorders including inpatient and outpatient services. I understand this elections applies to all persons identified on this application. Eligibility for this option is only upon initial enrollment. No Yes

Do you or any family members listed below have other coverage in addition to this plan? No Yes

If yes, name _____ Single Family

Are you covered by or eligible for Medicare Part A and/or Part B? No Yes If yes, attach a copy of Medicare card.

Effective Date: Part A _____ Part B _____

Are your spouse or any dependent covered by or eligible for Medicare Part A and/or Part B? No Yes If yes, attach a copy of Medicare card.

Effective Date: Part A _____ Part B _____

Are you, your spouse or any dependent covered by Medicare Part D? No Yes If yes, attach a copy of Medicare card.

Effective Date: _____

OTHER COVERAGE:

Do you or any family members included on this enrollment form currently have or have you had continuous health coverage for the last 12 months? No Yes If yes, complete section below

PROPOSED INSURED'S NAME	COMPANY NAME	GROUP/ INDIVIDUAL/ COBRA	TYPE OF COVERAGE	EFFECTIVE DATE	TERMINATION DATE

Do you, your spouse or any of your dependent applicants have past or current medical coverage through a contract or plan issued or administered by PreferredOne Community Health Plan (PCHP), PreferredOne Administrative Services, Inc. (PAS), or PreferredOne Insurance Company (PIC)? No Yes*

*If Yes, please provide:

Employer Name (for group coverage) _____

Name(s) of all covered person(s): _____

Member ID #: _____

*If Yes, by executing and submitting this application, you give PIC/PCHP permission to view all claims history for you, your spouse and dependents as a result of such coverage except for claims history that PAS obtained acting in its capacity as a Preferred Provider Organization (PPO). For proprietary reasons, PPO claims history information will not be reviewed as part of the PIC/PCHP underwriting process. Regardless of what type of coverage you have now or previously had through a PreferredOne entity, you must answer all questions on all parts of the Health Information questionnaire portion of this application fully and completely even if you believe that a PreferredOne entity has such information already.

COVERAGE SELECTION:

I am applying for one (1) of the following calendar-year deductible options:

2008 Options:	<input type="checkbox"/> PIC 5180	<input type="checkbox"/> PIC 5200	<input type="checkbox"/> PIC 5250	<input type="checkbox"/> PIC 5510
Single Contract Deductible	\$1,500	\$2,000	\$2,850	\$5,500
OR				
Family Contract Deductible	\$3,000	\$4,000	\$5,650	\$11,000

Health Information

A. Complete information is required below for each applicant. If you answer YES to any of these questions, please explain in section B, indicating which applicant the YES answer involves. Please attach a separate sheet if additional space is needed.

	YES	NO
Have you or any family member applying for coverage:		
1. Had an electrocardiogram, chest x-ray, or blood test or any other diagnostic testing of any kind or been hospitalized in the last 10 years? If yes, give name of physician or hospital and results.		
2. Been declined, charged additional premium, or had benefits excluded by any health or life insurance company in the last 10 years?		
3. Used tobacco and/or smokeless tobacco during the 24 months immediately preceding the date of this application? If yes, please indicate whether you, your spouse or both used tobacco or smokeless tobacco: <input type="checkbox"/> You <input type="checkbox"/> Your spouse <input type="checkbox"/> Both you and your spouse		
Have you or any family member applying for coverage had any diagnosis of, received treatment for, or consulted with a physician concerning:		
4. Lung or respiratory disorders, including but not limited to asthma, allergies, emphysema or chronic bronchitis?		
5. Musculoskeletal disorders or injuries, including but not limited to back disorders or injuries, scoliosis, temporomandibular joint disorder (TMJ), fibrositis, fibromyalgia, carpal tunnel syndrome, gout, arthritis, joint disorders or injuries, or amputation?		
6. Blood disorders, including but not limited to, anemia, or hemophilia in the past five years?		
7. Cancer or tumor(s)? List type, past and current treatment.		
8. Emotional, mental or personality disorders, including but not limited to, depression, anxiety, adjustment disorders, eating disorders, attention deficit disorders, hyperactivity, behavioral, or psychotic disorders?		
9. Nervous system disorders, including but not limited to, stroke, epilepsy, fainting, dizziness, seizures, headaches, migraines or any other disease or disorder of the brain or nervous system in the past five years?		
10. Endocrine or glandular disorders or injuries, including but not limited to, diabetes, thyroid, adrenal, pituitary, pancreas, or lymph node/gland enlargement?		
11. The heart or circulatory system condition including but not limited to, high blood pressure, heart attack, heart murmur, chest pain, irregular heartbeat, varicose veins, phlebitis or elevated cholesterol? Please provide last blood pressure reading and cholesterol level if known of each adult applying for coverage. Applicant: Blood Pressure _____ Cholesterol _____ Spouse: Blood Pressure _____ Cholesterol _____		
12. Digestive disorders or injuries, including but not limited to, stomach or duodenal ulcer, other ulcer, hernia, colitis, hepatitis, chronic diarrhea, jaundice, cirrhosis, or any disorder of the liver, gallbladder, stomach, intestine or rectum in the past five years?		
13. Any disease of the eyes, ears, nose, throat, tonsils or sinuses in the past five years?		
14. Reproductive system disorders, including but not limited to, any disease or disorder of the breast or reproductive organs (male and female), complication of breast implants, infertility, abnormal menstrual periods, or sexually transmitted disease in the past five years?		
15. Date of last pap smear _____ Results _____ Have you been instructed to have a repeat pap smear or any follow-up treatment or tests as a result of your last pap smear?		
16. Had surgery, diagnostic testing, treatment or referral to a medical care provider recently completed or recommended or scheduled that has not been completed?		
17. Immune system disorders, including but not limited to, HIV positive, AIDS, lupus, collagen disease, scleroderma, or any other connective tissue disease?		
18. Renal disorders or injuries, including, but not limited to, kidney, bladder, prostate or urinary disorders or injuries?		
19. Congenital or developmental disorders or injuries, including but not limited to, cleft palate, club foot, congenital heart defects, chromosomal abnormalities, physical or cognitive delays or autism?		
20. Skin disorders, acne, psoriasis, warts, or other in the past five years?		
21. Treatment for, or participation in any organization for alcoholism/chemical dependency, or been convicted for or had a driver's license suspended for DWI/DUI or moving violation in the past five years?		
22. Result of an accident including but not limited to (motor vehicle, motorcycle, ATV, blunt force, etc.) in the past 24 months?		
23. A medical condition or injury in the last five years not already listed on this application?		
24. Does any person have any fixation/prosthetic devices presently, including but not limited to plates, screws, pins, implants (including breast implants), shunts, pacemakers or valve replacements?		
25. Is any family member now pregnant or an expectant parent, even if they are not applying on this application? If yes, expected date of birth: _____ Maternity coverage will begin after the member has been eligible under the PIC individual contract for 18 months.		
26. Any condition that may require medical, surgical, or hospital care?		
27. Gastric bypass surgery?		

B. ADDITIONAL MEDICAL DETAILS:

If you have answered yes to any of the health questions, please complete this section. Give complete details, attach a separate sheet if additional space is needed.

Question #	Name of person	Date(s) occurred/treated	Remaining effects	Complete name and address of physician/hospital where treated

Explanations of "yes" answers to medical conditions. Include date of onset, name of condition, treatment and days in hospital.

Question #	Name of person	Date(s) occurred/treated	Remaining effects	Complete name and address of physician/hospital where treated

Explanations of "yes" answers to medical conditions. Include date of onset, name of condition, treatment and days in hospital.

Question #	Name of person	Date(s) occurred/treated	Remaining effects	Complete name and address of physician/hospital where treated

Explanations of "yes" answers to medical conditions. Include date of onset, name of condition, treatment and days in hospital.

Question #	Name of person	Date(s) occurred/treated	Remaining effects	Complete name and address of physician/hospital where treated

Explanations of "yes" answers to medical conditions. Include date of onset, name of condition, treatment and days in hospital.

C. MEDICATIONS:

Please list all medications taken for any proposed insured in the past 24 months.

Name	Drug Name	Condition	Currently taking? (Yes or No)	Dosage

D. REGULAR PHYSICIAN:

Please list regular physician or medical practitioner for each proposed insured: (If none, provide last doctor seen, date, reason and results.) Attach additional sheet if necessary.

Primary Proposed Insured's Physician _____

Address _____

Date Last Seen _____ Reason and Results _____

Date of Last Routine Physical _____ Results _____

Spouse's Physician _____

Address _____

Date Last Seen _____ Reason and Results _____

Date of Last Routine Physical _____ Results _____

Child's Name _____ Physician _____

Address _____

Date Last Seen _____ Reason and Results _____

Date of Last Routine Physical _____ Results _____

Child's Name _____ Physician _____

Address _____

Date Last Seen _____ Reason and Results _____

Date of Last Routine Physical _____ Results _____

Child's Name _____ Physician _____

Address _____

Date Last Seen _____ Reason and Results _____

Date of Last Routine Physical _____ Results _____

Child's Name _____ Physician _____

Address _____

Date Last Seen _____ Reason and Results _____

Date of Last Routine Physical _____ Results _____

PreferredOne Insurance Company (PIC) complies with the Minnesota Insurance Fair Information Reporting Act. In compliance with this law, this notice is to inform the applicant that during the health underwriting process personal information about the applicant may be collected from persons other than the applicant. The information collected by PreferredOne Insurance Company or the insurance broker may in certain circumstances be disclosed for health underwriting purposes to third parties without authorization of the applicant, but only if permitted by applicable state and federal privacy laws. The applicant has a right to see the personal information collected about the applicant in the health underwriting process, and there is a procedure by which the applicant may correct inaccurate personal information collected. For further information about these rights, contact the PreferredOne Insurance Company individual sales customer service area.

On behalf of myself, my spouse and my dependent applicants, I authorize any physician, medical practitioner, hospital, clinic, veterans' administration facility, other medically related facility, PreferredOne Insurance Company and any entity affiliated with PreferredOne Insurance Company, including but not limited to PreferredOne Community Health Plan or PreferredOne Administrative Services, Inc. (PAS), who has treated or has claim history (other than claim history that PAS obtained acting in its capacity as a Preferred Provider Organization (PPO)) or has medical information about me, my spouse and/or my dependent applicants, to release to PreferredOne Insurance Company information as to diagnosis, treatment, and prognosis with respect to any physical or mental conditions of me (or, if requested, my dependent applicants) for insurance underwriting and plan administration purposes. On behalf of myself, my spouse and my dependents, I, my spouse and my dependents further agree to authorize, execute and submit all authorizations and releases required by any physician, medical practitioner, hospital, clinic, veterans' administration facility, or other medically related facility who has treated, has claim history or has medical information about me, my spouse and/or my dependents to release to PreferredOne Insurance Company information as to diagnosis, treatment and prognosis with respect to any physical or mental conditions of me or if requested, of my spouse or dependents for insurance underwriting purposes and/or plan administration purposes. These authorizations exclude the release of information about HIV (AIDS virus) tests which were administered: 1) to a criminal offender or crime victim as a result of a crime that was reported to the police; 2) to a patient who received the services of emergency medical personnel at a hospital or medical facility; or 3) to emergency medical personnel who were tested as a result of performing emergency medical services. This authorization also excludes psychotherapy notes.

This authorization shall remain valid as long as I am continually covered by the medical plan in which I am enrolling with this form. I agree that a copy of this authorization shall be valid as the original. Information released pursuant to this authorization is released to an entity subject to the Health Insurance Portability and Accountability Act (HIPAA). This authorization may be revoked by submitting a written revocation to PreferredOne Customer Service. Such revocation will not effect actions taken prior to the revocation. Because this authorization is for underwriting, risk rating, and enrollment purposes, revocation of this authorization or failure to give this authorization may result in denial or termination of coverage.

I represent that the answers to the questions and statements made on this form are true and complete.

I agree to notify PreferredOne Insurance Company of any change and I understand that I must update this form and resubmit it if anything changes to my (or my dependent applicants) health condition that affects the information on this form between submission of the form and effective date of coverage. I understand and agree that PreferredOne Insurance Company will act in reliance upon the information I have provided herein. I understand that providing false information or omission of relevant information on this form which materially affects either the acceptance of risk or hazard assumed by PreferredOne Insurance Company may result in denial of claims, retroactive cancellation of coverage, or an increase in premiums, and may be considered insurance fraud. I understand that, subject to the terms and conditions of the contract under which I am enrolling for coverage, I may be subject to a pre-existing condition limitation.

I agree that a photographic copy of this authorization shall be as valid as the original.

Applicant's signature	Date	Print full name
Spouse's signature (if applying for coverage)	Date	Print full name
Dependent signature (if over 18 & applying for coverage)	Date	Print full name
Additional dependent signature(s) (if over 18 & applying for coverage)	Date	Print full name
Dependent/guardian signature (if minor(s), with legal guardian)	Date	Print full name
Agent's signature (if applicable)	Date	Print full name

Electronic Payment Plan (EPP) – REQUIRED

PreferredOne Insurance Company (PIC) offers its Electronic Payment Plan (EPP) premium collection feature. This service utilizes the Automated Clearing House (ACH) system to effectively and accurately debit your designated account each payment cycle. The ACH funds transfer system is used nation-wide by member financial institutions. On or near the 8th of each month we will initiate a funds transfer from your account for the amount due. This process will continue on a monthly basis during the policy period. In the event your account lacks sufficient funds, additional fund transfers from your account will occur. You may be charged up to a \$25 processing fee for each occurrence.

Advantages of using the Electronic Payment Plan to pay your premiums:

- Ensures proper credit to your account.
- Reduces the potential for lost or stolen checks.
- Reduces postage costs and check writing fees.

Here's how to sign up for the plan:

- Complete the Authorization Form below and attach a voided check or savings deposit slip from the account designated for the electronic payment plan.
- If you are mailing this Authorization Form along with an application for coverage, please be sure you include a \$20 non-refundable application fee.
- If your policy is approved with an effective date other than the 1st of the month, the premium for that month will be pro-rated. The funds transfer for the following month will include the current month premium plus the pro-rated premium for the previous month.

Electronic Payment Plan (EPP) Authorization Form

Name on bank account: _____

Bank ABA/routing number: _____

Bank account number: _____

Bank name: _____ Telephone: _____

City: _____ State: _____ Zip code: _____

I authorize PIC and the bank named above to initiate monthly withdrawals from my checking or savings account, as indicated. This agreement will remain in effect until I notify PIC and my bank in writing to cancel it.

Print name of applicant _____ Social Security Number _____

Signature of bank account holder _____ Date _____

Signature of bank account holder (if joint account) _____ Date _____

If you have questions, please contact PIC at 763.847.4477 or 1.800.997.1750.

PreferredOne Insurance Company
6105 Golden Hills Drive
Golden Valley, MN 55416
763.847.4477 1.800.997.1750



**NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE
MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW**

If the insurer that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life and Health Insurance Guaranty Association
4760 White Bear Parkway Suite 101
White Bear Lake, MN 55110
Phone Number: 651.407.3149 Fax Number: 651.407.3150

The maximum amount the guaranty association will pay for all policies issued on one life by the same insurer is limited to \$300,000. Subject to this \$300,000 limit, the guaranty association will pay up to \$300,000 in life insurance death benefits, \$100,000 in net cash surrender and net cash withdrawal values for life insurance, \$300,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, \$100,000 in annuity net cash surrender and net cash withdrawal values, \$300,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be \$300,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to \$100,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than \$7,500,000 in claims from all Minnesota residents covered by the plan. If total claims exceed \$7,500,000, the \$7,500,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.