

PART I

A. INSTRUCTIONS AND NOTICES FOR APPLICANT AND AGENT

Thank you for applying to American Community Mutual Insurance Company (*herein referred to as American Community*). Your health insurance is important protection and the application process is a crucial part of securing coverage for you and your family. Please take the time to carefully complete this application; your answers will become part of the underwriting process and the insurance contract. When completing the application, please follow these procedures:

DO NOT COMPLETE THIS APPLICATION UNTIL YOU HAVE READ THE CURRENT PRODUCT BROCHURE AND FULLY UNDERSTAND THE BENEFITS AND EXCLUSIONS AND LIMITATIONS

1. The Application is to be completed by all Proposed Insureds. Children only policies require the parent or guardian who has custody and care of the children to complete and sign the application. Dependents age 16 and over must sign the application.
2. Print in black ink only. Signatures are to be in writing and must be legible.
3. All questions must be answered in full, or the application may be returned to you and may result in a delay in processing. Most common causes for delay in underwriting are missing or incomplete information such as:
 - Date of Birth
 - Height and Weight
 - Social Security Number
 - County
 - Plan, Coinsurance, Deductible, Optional Benefits and PPO Network Requested
 - Existing Coverage and Replacement information
 - Dependent Student Status (Full time student means enrolled in an accredited college, university, trade or secondary school for 12 or more credit hours)
4. Corrections to answers can be made by drawing a straight line through the incorrect answer and printing the correct response above the lined-out answer. **Applicant** must then initial and date the correction.
5. Errors in signature(s) and/or date/time cannot be corrected. A new application is required.
6. Applications must be completed and mailed as soon as possible so they are received at the Home Office of American Community within 30 days of the application date. If the application is received more than 30 days after the date the application was signed, it will be returned. This application is void if not approved within 90 days after the date the application was signed.
7. Unless required by law, the completion of this application and submission of any estimated initial premium does not:
 - a) provide interim coverage;
 - b) guarantee coverage;
 - c) guarantee issuance of a policy
8. **Unfold page 8 prior to filling out application**

Do not cancel your existing insurance coverage until your new American Community policy has been issued and the policy has been delivered and fully accepted by you.
You will be notified of the effective date of your policy.

The policy will become effective when:

- a) All underwriting requirements are met;
- b) Application is approved by American Community's Home Office Underwriting Department;
- c) Any outstanding delivery requirements (amendments/exclusion riders) to the policy have been signed by the Applicant and received by American Community;
- d) The first modal premium has been received by American Community; and
- e) The policy is issued by American Community's Home Office and received by the applicant.

B. TYPE OF APPLICATION:

- New Application Rewrite of Existing American Community Plan New Application for Children Only

C. SCHEDULE OF PERSONS PROPOSED FOR INSURANCE

1. **List all Family Members.** If children are to be insured, include all children, stepchildren and adopted children of the Applicant who are dependent on the Applicant and **are at least 15 days old but have not reached their 22nd birthday.** Include maiden names of females in parentheses.

Full Name First-Middle-Last (Maiden Name)	Relationship to Applicant	Sex M/F	Date of Birth	Full Time Student (12 credit hours)	Marital Status	Height FT. IN.	Weight LBS.	Social Security Number
	Key Applicant							
	Spouse							
	Child			<input type="checkbox"/> Yes <input type="checkbox"/> No				
	Child			<input type="checkbox"/> Yes <input type="checkbox"/> No				
	Child			<input type="checkbox"/> Yes <input type="checkbox"/> No				
	Child			<input type="checkbox"/> Yes <input type="checkbox"/> No				
	Child			<input type="checkbox"/> Yes <input type="checkbox"/> No				

2. Residence Address

Street		
City	State	Zip
County		

3. Billing Address if other than Residence Address

Name		
Street		
City	State	Zip

4. If any proposed applicant does not live at the above residence, explain: _____

5. Driver's License Number

Key Applicant	State
Spouse	State
Dependent	State

6. Contact Numbers

Home Phone Number
Work Phone Number
Email Address

7. Occupation

Key Applicant	Employer	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Self-Employed
Spouse	Employer	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Self-Employed

D. EXISTING COVERAGE AND REPLACEMENT

1. Are any Applicants covered by other health insurance now or has an application been made by any of the Applicants for any type of medical insurance? Yes - Complete section below No

Applicant(s) Name(s) (First-Middle-Last)	Company Name	Group or Individual	Policy Number	Type of Insurance	Effective Date	Termination Date

2. Will the proposed American Community coverage replace or change any existing health insurance? Yes No

3. If health insurance is being replaced, replacement form RAS-IL (2002) must be signed and submitted with this application. Document the following information:

Insurance Replaced: <input type="checkbox"/> Individual <input type="checkbox"/> Group	Coverage (circle)	Start Date	End Date
Group Certificate Number	Medical		
Individual Policy Number	Prescription Drug		
Key Insured's Name	Dental		
Participant's Name(s)	Vision		

4. Have any Applicants ever been declined, postponed, rated or charged an extra premium or had a portion of coverage excluded for medical or disability insurance? Yes - Give details below No

E. PREMIUMS PAYABLE - Premium is calculated at age last birthday, based on the effective date requested for this insurance.

*Estimated Modal Premium as Quoted by Agent: \$ _____

Billing Options:

Monthly** Quarterly Semi-Annually Annually EFT New List Bill** List Bill Agreements Required List Bill # _____

Initial Premium Payment Options:

Visa MasterCard Card Number _____ Exp. Date _____

I authorize American Community to charge the full initial premium payment to my Visa/MasterCard.

Signature of Cardholder

Date Signed

Electronic Funds Transfer (EFT) from Checking Account (COMPLETED EFT AUTHORIZATION FORM REQUIRED) I acknowledge that American Community will notify me of the exact amount and approximate date of the initial checking account withdrawal prior to the withdrawal date. This option is only available if regular monthly premium payments are also to be withdrawn from the same checking account.

Check. Amount Enclosed \$ _____ (minimum one month's premium; two months' minimum premium recommended with application if effective date requested is within 30 days of application date).

**ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY
DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK**

In the event of a balance being due upon approval of this application, I authorize American Community to:

Charge my Visa MasterCard for the balance due. Card Number _____ Exp. Date _____

Signature of Cardholder

Date Signed

Withdraw the amount due from my checking account (COMPLETED EFT AUTHORIZATION FORM REQUIRED). This option is only available if regular monthly premium payments are also to be withdrawn from the same checking account. I acknowledge that American Community will notify me of the exact amount and approximate date of the initial checking account withdrawal prior to the withdrawal date.

Bill me

* The estimated premium is only an estimate and the actual premium billed may be different depending on the information provided in this application and the time of underwriting approval.

**Administrative Charge: Once approved, an additional Monthly Billing Fee of \$4.75 will be applied (fee is waived for EFT, Quarterly, Semi-Annually or Annually). A \$10 per month Billing Fee will be charged for List Bill.

F. AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER FOR PREMIUM PAYMENT

Electronic Funds Transfer (EFT) is the automatic, monthly transfer of funds from your checking account to American Community for the express purpose of premium payment. The only participation requirement is that you maintain a regular checking account.

Name	Financial Institution
Address	Address
Telephone	Account Number
Account and Authorization Signature(s)	

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 understand that this withdrawal will automatically continue until I notify American Community in writing to stop. I agree to allow American Community reasonable time (at least 14 days) to do so.

Signature of Key Applicant/Owner

Date Signed

Attach Voided Check Here
A Deposit Slip Is NOT Acceptable

Returned Check Fee: If any premium payment made directly by check or by Electronic Funds Transfer (EFT), is returned for non-sufficient funds, a \$20 nonrefundable service fee will be applied. This fee will be due with your next premium payment.

G. PLAN OF HEALTH INSURANCE AND OPTIONAL BENEFITS APPLIED FOR

Mark appropriate deductible, co-insurance and optional benefit(s) for plan selected

Plan	Medalist	Community Med HSA
Co-Insurance	<input type="checkbox"/> 80% of \$5,000/50% of \$10,000 <input type="checkbox"/> 80% of \$10,000/50% of \$20,000 <input type="checkbox"/> 70% of \$5,000/50% of \$10,000 <input type="checkbox"/> 70% of \$10,000/50% of \$20,000	<input type="checkbox"/> Check this box if selecting an HSA. You must also complete and sign the Addendum to the Individual Health Insurance Application Form # HSA-APP-ADD (IL) .
Copay with Deductible	<input type="checkbox"/> \$25, \$500/\$1,000 <input type="checkbox"/> \$30, \$1,000/\$2,000 <input type="checkbox"/> \$35, \$1,500/\$3,000 <input type="checkbox"/> \$40, \$2,500/\$5,000 <input type="checkbox"/> \$40, \$5,000/\$10,000	
OR Deductible Only	<input type="checkbox"/> \$500/\$1,000 <input type="checkbox"/> \$1,000/\$2,000 <input type="checkbox"/> \$1,500/\$3,000 <input type="checkbox"/> \$2,500/\$5,000 <input type="checkbox"/> \$5,000/\$10,000	
Optional Benefits	<input type="checkbox"/> Dental <input type="checkbox"/> Maternity <input type="checkbox"/> \$1,000 Prescription Drug Deductible	
PPO Network	<input type="checkbox"/> HealthLink <input type="checkbox"/> MultiPlan <input type="checkbox"/> PHCS <input type="checkbox"/> Open Access II	

H. QUESTIONS APPLY TO EACH APPLICANT PROPOSED FOR INSURANCE

- | | Yes | No | | Yes | No |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Are you, your spouse, significant other person, or any dependent or adopted child (whether or not listed on this application) now pregnant or have an adoption pending? If yes, Do Not Submit Application . | <input type="checkbox"/> | <input type="checkbox"/> | 7. Have you in the past 10 years, used alcoholic beverages? If yes, who? _____
For how long? _____
How many drinks daily? _____ weekly?
<i>(One drink equals one 12 oz. beer or one 4 oz. wine or 1 oz. of alcohol)</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you a United States Citizen? If no, complete the following:
Name: _____
Country: _____ | <input type="checkbox"/> | <input type="checkbox"/> | 8. Have you had your driving license suspended or revoked for any reason in the past 10 years? If yes, give applicant(s) name(s), dates and details: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you lived outside the United States within the past 12 months? If yes, who? _____
Where? _____
Date of Re-entry? _____ | <input type="checkbox"/> | <input type="checkbox"/> | *9. During the past 10 years, have you been advised to limit your use of alcohol, been told to seek treatment for or been treated for alcohol or drug usage, or been a member of Alcohol Anonymous or other similar group? If yes, give applicant(s) name(s) and details: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you plan to travel outside the United States in the next 12 months? If yes, who? _____
Where? _____
How long? _____ | <input type="checkbox"/> | <input type="checkbox"/> | *10. Have you, in the past 10 years, used cannabis, barbiturates, narcotics, hallucinogenic drugs or other controlled substances? If yes, give applicant(s) name(s) and details: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you engage in scuba or sky diving, organized racing, flying or other hazardous activities? If yes, who? _____
What activity? _____
If yes, submit Aviation/Avocation Questionnaire | <input type="checkbox"/> | <input type="checkbox"/> | *11. Have you, in the past 10 years, had an alcohol or drug related arrest? If yes, give applicant(s) name(s) and details: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you in the last 10 years smoked cigarettes, cigars, pipes or used any form of tobacco, including chewing tobacco or nicotine products? If yes, who? _____
Form of tobacco used: _____
Number of years used: _____
Date of last use (if quit): _____ | <input type="checkbox"/> | <input type="checkbox"/> | *If questions 9, 10 or 11 are answered yes, submit an Alcohol and Drug Questionnaire for each Applicant. | | |

PART II

MEDICAL HISTORY

Questions apply to each Applicant proposed for insurance. Give complete details of "Yes" answers, including date, details, diagnosis, treatment and name and address of doctor or medical facility (attach separate sheet if necessary).

American Community underwriters will not routinely request medical records on you or your family members.

Benefits will be paid for a sickness, injury or condition that existed prior to the time insurance is effective only if such sickness, injury or condition is fully and completely disclosed on this application and not excluded from coverage by a rider or policy exclusion.

For any condition listed, you must complete the Authorization under Part III on page 8.

A. Within the past 10 years has any Applicant had symptoms of, had a diagnosis of, received treatment, including medications for, or consulted with a physician or medical professional concerning:

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. The lungs or respiratory system including, but not limited to, hayfever or other allergies, sinus infections, asthma, bronchitis, tuberculosis, pneumonia, emphysema or sleep apnea? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. The heart or circulatory system including, but not limited to, edema, poor circulation, clots, high blood pressure, heart attack, heart murmur, chest pain, irregular heartbeat, varicose veins, phlebitis, hypertension, elevated cholesterol/triglycerides? | <input type="checkbox"/> | <input type="checkbox"/> |

(continued on next page)

- | | Yes | No |
|---|--------------------------|--------------------------|
| 3. The digestive system including, but not limited to, Crohn's disease, polyps, rectal bleeding, ulcer, gastric reflux, gastritis, intestinal disorder, colitis, irritable bowel syndrome, gall bladder, hemorrhoids, hernia, disorder of the pancreas, spleen, or liver including but not limited to, hepatitis, jaundice or cirrhosis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. The nervous system including, but not limited to, epilepsy, convulsions, migraines, headaches, paralysis, Parkinson's Disease, stroke, vertigo or fibromyalgia? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Mental disease or nervous disorder including, but not limited to, any emotional disorder, anxiety, depression, attention deficit disorder, eating disorder or psychiatric treatment or counseling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. The genito-urinary system including, but not limited to, any kidney disorder, kidney stones, cystitis, prostatitis, bladder infections or sexually transmitted disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Diabetes, high or low blood sugar or any disorder of the thyroid gland or other glandular disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. The muscular or skeletal system including, but not limited to, multiple sclerosis, muscular dystrophy, cerebral palsy, Lou Gehrig's Disease (ALS), arthritis, gout, lupus, rheumatism, temporomandibular joint disease (TMJ), osteoporosis, any back or spine disorder or treatment of any muscular or neuromuscular disorder or any manipulation therapy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Blood or lymph disorders including, but not limited to, anemia or lymphadenopathy (swollen lymph nodes)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Cancer, Hodgkin's, leukemia or lymphoma? Provide date of diagnosis, type of cancer and treatment received _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Any immune disorder (except AIDS, ARC, or HIV virus referred to below), autoimmune disorder or chronic infection including, but not limited to, Lymes Disease and Chronic Fatigue Syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Cyst, tumor, growth of any kind, any skin condition or breast disorder including fibrocystic disease? Provide date of diagnosis, type of condition and treatment received _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Any disorders of the eyes, ears, nose or throat including, but not limited to, ear infections or ear tubes, tonsils or adenoids, or any speech or hearing impairments? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Any disorder of the reproductive organs including, but not limited to, disorders of the penis, testes, prostate, vagina, ovaries, cervix or uterus? | <input type="checkbox"/> | <input type="checkbox"/> |

B. Within the past 10 years has any applicant:

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Been tested positive for the AIDS (HIV) virus? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Been treated or diagnosed by a physician or a licensed medical professional as having AIDS or ARC (AIDS Related Complex)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Had surgery or any surgical procedures, sought advice or received any medical or surgical treatment from a medical professional? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Had diagnostic testing, treatment or surgery recommended or scheduled that has not been completed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Had an electrocardiogram, chest x-ray, or blood study or any other diagnostic testing of any kind or been hospital confined? If yes, give name of applicant and name of physician or hospital and results _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Had abnormal results on any of the following: Blood Count, Blood Test, Urine Test, X-Ray, Ultrasound, EKG (electrocardiogram), or other tests. If yes, please explain _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Had a routine medical exam? Results _____ | <input type="checkbox"/> | <input type="checkbox"/> |

C. Does any applicant:

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Had/Have any symptoms or conditions for which they intend to seek medical advice or treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Had/Have any fixation/prosthetic devices including, but not limited to, plates, screws, pins, implants (including breast implants), shunts, pacemakers or valve replacements? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Currently take, or have taken within the past 6 months, any medication or medical treatment of any kind? | <input type="checkbox"/> | <input type="checkbox"/> |

D. Has any female applicant:

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Ever had complications of pregnancy, including, but not limited to, cesarean section delivery or miscarriage? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Ever been diagnosed or treated for endometriosis, fibroids, excessive bleeding, polycystic ovaries, infertility, abnormal pap smear or irregular menstruation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever been instructed to have a repeat PAP Smear or any follow-up treatment or tests as a result of a PAP Smear? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Last PAP Smear: | | |
| Name _____ Date _____ Results _____ | | |
| Physician's Name _____ Phone Number _____ | | |
| Name _____ Date _____ Results _____ | | |
| Physician's Name _____ Phone Number _____ | | |

E. Document details of all "Yes" answers to questions in Part II Medical History, Sections A, B, C and D on the previous pages.

Question Number & Individual's Name	Condition	Diagnosis & Results of Visit	Procedure/Surgery/ Treatment/Consultation	Medication/ Dosage	Date First Seen	Date Last Treated	Name, Address & Phone Number of Physician, Medical Professional Hospital or Institution *

* For every provider listed above, you MUST complete the Authorization under Part III on page 8.

You may use this space for additional information

F. DECLARATIONS

I certify that I am applying for personal insurance which is not part of any employer sponsored plan, no part of the premium will be paid by my employer and all persons to be insured are residents of Illinois. I understand and agree that if any action by me, my employer or any government or regulatory agency cause the policy applied for to be deemed group insurance, the policy will end on the date of such action. I have personally completed this application and I represent that the statements and answers are true and complete to the best of my knowledge and belief, and I understand that this application (Part I, Part II, Part III and any other required parts) shall not be binding until approved by American Community at its Home Office. The undersigned Applicants and Agent certify that each person proposed for insurance has read the complete application and that he/she realizes that any false statement or misrepresentation, if material to the risk, may result in loss of coverage under this policy. I acknowledge that I have been provided with a Notice of Your Privacy Rights. It is agreed that no agent is authorized to make any contract for American Community or to determine insurability or to waive or alter any conditions of the application, or the policy, and that notice to or knowledge of the agent as to any facts, whenever given, shall not be deemed notice to American Community unless recorded in this application, and that American Community shall not be bound by any act or statement of the agent not contained in this application. I understand that I or any person proposed for insurance may request to be interviewed in connection with the preparation of an investigative consumer report. I acknowledge that disclosure of the name and address of my regular or attending physician does not constitute full disclosure (as required under this application) of the date, details, diagnosis, treatment, or remaining effects of any of my medical conditions. I acknowledge receipt of the Outline of Coverage for the plan of health insurance selected in Part I, Section G of this application.

NOTICE: 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 may be guilty of insurance fraud.

If requested by American Community, I agree to provide any additional information necessary to complete the underwriting process, including, but not limited to completing additional questionnaires, providing additional or specialized authorizations to obtain medical information or speaking to an American Community representative.

G. CONSENT

I consent to any consumer reporting agency that has any record, public record or knowledge of the character, general reputation, personal characteristics, mode of living or type of risk of any persons proposed for insurance to give to American Community, its legal representatives or its reinsurers, any such record or knowledge for purposes of underwriting insurance. This includes, but is not limited to, motor vehicle driving records and criminal history.

I consent to any physician, hospital, clinic, pharmacy, other medical or medically related facility and insurance company, health information repository, its agents, business associates, or legal representatives to give to American Community, its legal representatives or its reinsurers any information or records or knowledge of the health, except for psychotherapy notes, of any persons proposed for insurance to carry out treatment, payment or health care operations.

A photographic copy of this consent shall be as valid as the original for 30 months from the date signed. I know that I, or my authorized representative, may request and are entitled to receive a copy of this consent.

Effective Date Requests

- If you are replacing coverage or are ending COBRA you may request a special effective date.
Applicant requests an effective date of _____.
- If replacing American Community Individual Coverage now in force, the future effective date will be the paid-to-date of the policy being replaced.
- If you are not replacing coverage, the earliest effective date that you will be assigned is 30 days after the signed date of the application. The effective date will be assigned after the policy has been approved and issued by the American Community Home Office.
- In no case will an effective date prior to the application date be permitted. The latest effective date permitted is 90 days after the date signed.

I understand that my statements and answers in this application must continue to be true as of the date I receive the policy. I understand that if my health or any of my answers or statements change prior to delivery of the policy, I must inform American Community in writing. I understand that failure to do so may result in my application being denied or rescission of the policy.

Signature of Key Applicant/Owner	Signature of Spouse (if proposed for insurance)	
Signature of Dependent (age 16 and over)	Signature of Dependent (age 16 and over)	
City and State	Time	Date Signed

Agent's Certification
Each question has been asked by me of the Applicant(s). All answers have been accurately recorded. I am not aware of any mental or physical impairment or deformity of any Applicant which is not disclosed on the application. I did witness the signing of this application by the Applicant(s). I did not witness the signing of this application by the Applicant(s) but I fully explained the questions on the application to the Key Applicant over the telephone. To the best of my knowledge and belief, replacement of health insurance is is not involved.

Signature of Licensed Agent Date Signed Print Agent's Name Agent Number Agent's Business Phone and Fax Numbers

Errors in signature(s), time or date signed cannot be corrected. A new application is required.

IF THE APPLICATION IS RECEIVED MORE THAN 30 DAYS AFTER THE APPLICATION DATE IT WILL BE RETURNED. THIS APPLICATION IS VOID IF NOT APPROVED WITHIN 90 DAYS OF THE DATE SIGNED.



39201 Seven Mile Road, Livonia, Michigan 48152-1094
(800) 991-2642 (734) 591-9000 (734) 591-4628 Fax
www.american-community.com

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 (H.H.S.)
 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 American Community at 1-800-991-2642 if you have any questions or comments.

Effective: April 14, 2003