

When mailing use postage stamp only – No postage meter  
The Policy does not provide portability of prior coverage. As a result, any injury, sickness, or pregnancy for which you have incurred charges, received medical treatment, consulted a health care professional, or taken prescription drugs within 12 months of the effective date of the policy will not be covered under the Policy.

<b>1</b>	<b>A. Requested Effective Date</b> ____/____/____ You may request a specific effective date (may be any day of the month) as long as the application and premium are received by Allied before the requested effective date. See brochure for details on effective dates.	<b>B. PLAN OPTIONS:</b> <input type="checkbox"/> Monthly Billing <input type="checkbox"/> Prepay Plan – Number of Months (1 to 6) _____ <b>Deductible:</b> <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000 <b>\$500 Supplemental Accident Option:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>Maximum Coverage Period: Six (6) Months – This coverage does not renew</b> <input type="checkbox"/> I am applying for Child Only coverage – see brochure for application instructions
----------	--	--

APPLICANT'S NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)	SOCIAL SECURITY NUMBER		
RESIDENCE ADDRESS			
CITY	STATE	ZIP	DAYTIME TELEPHONE (Include Area Code)
BILLING NAME/ADDRESS (IF DIFFERENT THAN ABOVE) PLEASE INCLUDE FULL MAILING ADDRESS AND PHONE NUMBER			
APPLICANT'S DATE OF BIRTH	AGE	GENDER	Applicant – Must be over age 17 and under age 65 (unless applying for child only coverage) Spouse – Must be under age 65 Dependent Children – Must be under age 19

**Complete this section to insure your spouse and/or children**

	FULL NAME (First Name, Middle Initial, Last Name)	DATE OF BIRTH	AGE	GENDER	SOC. SEC. NUMBER
<b>3</b>	Spouse				
	Child #1				
	Child #2				
	Child #3				

**4**

**Please answer the following questions completely and accurately (any "YES" answer means coverage cannot be issued):**

A. Are you over age 64, or is your Dependent Spouse to be insured over age 64, or is any Dependent Child to be insured over age 18? .....  YES  NO

B. Are you or any Dependent to be insured covered under other hospital, major medical, group health or other medical insurance coverage?.....  YES  NO

C. Are you or any Dependent to be insured a member of the armed forces of any country, state or international organization, other than on reserve duty for 30 days or less? .....  YES  NO

D. Are you or any Dependent to be insured currently pregnant, or if insuring dependents, are you an expectant father or planning on adopting?.....  YES  NO

E. Within the last five (5) years, have you or any Dependent to be covered been hospital confined for five (5) consecutive days or longer? .....  YES  NO

F. Are you or any Dependent to be insured overweight AND been diagnosed with high blood pressure (whether or not treated or controlled)? Overweight is any male over 300 pounds or female over 250 pounds.....  YES  NO

G. Are you or any Dependent to be insured overweight AND been diagnosed with elevated cholesterol (whether or not treated or controlled)? Overweight is any male over 300 pounds or female over 250 pounds.....  YES  NO

H. Within the last five (5) years, have you or any Dependent to be covered seen any medical professional, been recommended to see a medical professional, been treated, received medication or received abnormal test results for, or been diagnosed with, any of the following conditions?  
 • Cancer (excluding basal cell), Diabetes, Hepatitis, Liver Disorder, Polycystic Kidney Disease, Renal Failure, AIDs or tested positive for HIV (WI applicants do not need to disclose HIV test results);  
 • Heart disorder – including but not limited to chest pain, heart failure, rhythm disturbances or heart attack;  
 • Circulatory system disorder – including but not limited to stroke or deep vein thrombosis/phlebitis (does not include high blood pressure);  
 • Nervous System disorder – including but not limited to Muscular Dystrophy; or  
 • Mental/Nervous disorder, Substance Abuse or Alcoholism requiring hospitalization.....  YES  NO

I. If all persons to be insured are United States citizens, please answer "No" to this question. If any person to be insured is not a United States citizen, has that person resided outside the United States at any time over the last 24 months? .....  YES  NO

J. Have you or any other person to be insured been covered under two or more individual Short-Term policies during the past 12 months?  YES  NO If "Yes", then this policy may not be issued. You must wait 6 months from the date of your last such policy to apply for a Short-Term policy.

**5**

I understand or acknowledge the following: (a) This is not a continuation of any previous medical plan, including any prior temporary health insurance plan; (b) If the application is declined and coverage is not issued, American Alternative Insurance Corporation's only obligation will be to return any premium paid; and (c) I received and reviewed the plan brochure, which serves as an outline of coverage.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

I authorize the disclosure of all nonpublic personal information and individually identifiable protected health information for me (and my dependent(s), if requesting dependent coverage), including but not limited to employment status, other insurance coverage, diagnosis, prognosis, medical treatment or care and physical or mental conditions (including alcohol or drug dependency), by any physician, medical practitioner, hospital, other medical related facility, insurance company, employer or benefit plan having such information, to the Insurance Company or its legal representative, agent or vendor, for the purpose of approving enrollment and processing claims. I acknowledge and agree that this authorization shall be valid for two (2) years; that I may revoke it in writing at any time; that I may request a copy of this authorization; that enrollment and the processing of claims are not conditioned on my signing this authorization; that this authorization will be used as its own document, separate from the application; that a photocopy of this authorization shall be as valid as the original; and that I have authority to act as the personal representative of my dependent(s) (if requesting dependent coverage).

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_  
 STM 2006-2.IA (CO) Underwritten by American Alternative Insurance Corporation Policy Form #STM 2006-2

6

OPTIONAL AUTHORIZATION AGREEMENT FOR AUTOMATIC MONTHLY PREMIUM PAYMENTS

I authorize Allied National to charge my account as indicated below for my monthly insurance premium and fees. I understand my account will be charged once each month for the total amount shown as due on my monthly premium statement for the limited term of the policy of insurance issued to me. I understand that if a charge to my account is not honored, my insurance coverage could lapse prior to its termination date. I understand that if I wish to cancel my coverage prior to its termination date, I must inform Allied National of such cancellation prior to the end of the grace period corresponding to the date of cancellation. Please charge my monthly premium and fees against the following account.

NAME (as shown on account – please print) \_\_\_\_\_

CREDIT CARD:  MasterCard  Visa – Account Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

CHECKING/NOW ACCOUNT: Please attach a voided check from the account you wish billed for your coverage.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

COLORADO AREA FACTORS

(based on first 3 digits of zip code of the residence address)

800-806 ..... 1.50

807-816 ..... 1.40

**This Plan is available in other states. Please contact Allied for state availability.**

RATES/AREAS EFFECTIVE 01/01/12

Table with 4 columns: \$500 Deductible, \$1,000 Deductible, \$1,500 Deductible, \$2,500 Deductible. Each column has sub-columns for Age, Male, and Fem. Rows include age groups (0-29 to 60-64) and rates for Per Child, Supplemental Accident Rate, and Per Person.

RATE LOAD FACTORS

Table with 3 columns: EFFECTIVE DATE, PREPAY, MONTHLY. Rows show rate load factors for different time periods: 1/1/12 - 3/31/12, 4/1/12 - 6/30/12, 7/1/12 - 9/30/12, 10/1/12 - 12/31/12.

A. Applicant \$ \_\_\_\_\_

B. Spouse +\$ \_\_\_\_\_

C. Child(ren) +\$ \_\_\_\_\_

D. Subtotal =\$ \_\_\_\_\_

Area Factor X \_\_\_\_\_

Load Factor X \_\_\_\_\_

E. Premium Subtotal =\$ \_\_\_\_\_

(round to nearest \$) =\$ \_\_\_\_\_

F. Supp.Acc.Option +\$ \_\_\_\_\_

G. Monthly Fee +\$ **12.00**

H. Total Monthly Cost =\$ \_\_\_\_\_

PREPAY PLAN ONLY

I. Number of Months X \_\_\_\_\_

J. Prepay Total Cost =\$ \_\_\_\_\_

RATE CALCULATION:

1) Determine rates based on deductible chosen and sex and age of each person. For child(ren) rate multiply number of children by the per child rate.

2) Multiply the subtotal (D) of these rates by the Area Factor and the Rate Load Factor to get Premium Subtotal (E) and round to nearest dollar. The Rate Load Factor is determined by the requested effective date and whether choosing Prepay or Monthly billing.

3) Add rates for optional Supplemental Accident coverage if applicable.

Supplemental Accident rate is for each person applying (e.g. if applicant, spouse and 1 child apply, the rate is 3 times \$5 for a rate of \$15).

4) Add Monthly Fee to get Total Monthly Cost (H).

5) For Prepay ONLY – multiply H times number of months requested for Prepay total Cost (J).

NOTE- Business checks cannot be accepted. Payment must be made by credit card or personal check payable to Allied National.

Online enrollment and rating is available at tempmedsales.alliednational.com.

AGENT INFORMATION

SOLICITING AGENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Soliciting Agent's Name \_\_\_\_\_ Agency \_\_\_\_\_ Allied Agent # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Tel. ( ) \_\_\_\_\_ Pay Commissions to: \_\_\_\_\_ SS# or Tax ID# \_\_\_\_\_

Fax ( ) \_\_\_\_\_ Email \_\_\_\_\_

1) Is the soliciting agent a licensed agent in the applicant's state of residence?

Yes – If Yes, please send copy of state license.  No – If No, the agent is not authorized to solicit this coverage and the policy cannot be issued.

2) Is the soliciting agent currently appointed with American Alternative Insurance Corporation:

Direct with American Alternative Insurance Corporation? or  Through ALLIED or another Administrator? WHO? \_\_\_\_\_

Appointment fees: Allied National will pay fee for agent appointment.

DISTRIBUTORS/GENERAL AGENT NAME: