

1	<p>A. Requested Effective Date ____/____/____ 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.</p>	<p>B. PLAN OPTIONS: <input type="checkbox"/> Monthly Billing <input type="checkbox"/> Prepay Plan – Number of Months (1 to 6) _____</p> <p>Deductible: <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</p> <p>\$500 Supplemental Accident Option: <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Maximum Coverage Period: Six (6) Months – This coverage does not renew <input type="checkbox"/> I am applying for Child Only coverage – see brochure for application instructions</p>
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2	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
3	Spouse				
	Child #1				
	Child #2				
	Child #3				

4	Please answer the following questions completely and accurately (any "YES" answer means coverage <u>cannot</u> be issued):	
	A. Are you or any Dependent to be insured currently pregnant or receiving infertility treatments, or if insuring dependents, are you an expectant father or in the process of adoption or in the process of surrogate pregnancy?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	B. Within the last five (5) years, have you or any Dependent to be insured been hospital confined for any reason (other than bodily injury) for four (4) consecutive days or longer?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	C. 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.	<input type="checkbox"/> YES <input type="checkbox"/> NO
	D. 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.	<input type="checkbox"/> YES <input type="checkbox"/> NO
	E. Within the last five (5) years, have you or any Dependent to be insured, seen or been treated by any medical professional, or been recommended to see a medical professional, or received diagnostic testing, or received medication, or received abnormal test results for, or been diagnosed with, any of the following conditions?	
	<ul style="list-style-type: none"> • Alcohol Abuse, Alcoholism, Chemical Dependency or Substance Abuse; • Cancer or Tumor (excluding basal cell); • Chronic Obstructive Pulmonary Disease, Cystic Fibrosis, Emphysema, Pulmonary Embolism or Tuberculosis; • Diabetes; • Organ or Tissue Transplant; • Blood disorder – including but not limited to hemophilia or leukemia; • 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); • Immune disorders – including but not limited to Lupus, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC); • Kidney or Liver disorder – including but not limited to Hepatitis, Polycystic Kidney Disease or Renal Failure; • Nervous System disorder – including but not limited to Muscular Dystrophy; or • Mental/Nervous disorder requiring hospitalization 	<input type="checkbox"/> YES <input type="checkbox"/> NO
	F. Within the last twelve (12) months, have you or any Dependent to be insured been advised by any medical professional to have any medical treatment, diagnostic testing or surgery that has not been completed?	<input type="checkbox"/> YES <input type="checkbox"/> NO
G. If all persons to be insured are United States citizens, please answer "No" to this question. If any person to be insured is <u>not</u> a United States citizen, has that person resided outside the United States at any time over the last 24 months?	<input type="checkbox"/> YES <input type="checkbox"/> NO	

5	<p>I understand or acknowledge the following: (a) Any incomplete, misleading, deceptive or false information or statement, or other concealment, misstatement, misrepresentation or omission, material to and in this application, may result in rescission of the insurance contract and/or denial of insurance benefits; (b) This is not a continuation of any previous medical plan, including any prior temporary health insurance plan; (c) This insurance will not pay benefits for any Pre-Existing Condition (refer to the plan brochure and certificate of insurance for complete explanation); (d) By applying for this insurance coverage I am enrolling as a member of the settlor of Allied Group Insurance Trust; (e) 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 (f) I received and reviewed the plan brochure.</p> <p>It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.</p> <p>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).</p>
	<p>Applicant's Signature _____ Date _____</p> <p>STM 2006-1.1A (DC) Underwritten by American Alternative Insurance Corporation Policy Form #STM 2006-1</p>

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 _____

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

Alaska: 995-999 2.00	Illinois: 606 2.20 600, 602-605 1.90 601, 607-608 1.70 609,614-615, 620-622 1.40 610-613, 616-619, 623-629 1.30	Missouri: 630-631, 633, 640-641 1.60 645 1.50 634-639, 642, 644, 646-658 1.30	Pennsylvania: 150-152, 189, 192-194 1.80 153-188, 195-196, 1.60 190-191 2.00	West Virginia: 253, 260 1.60 251-252, 254-257 1.50 247-250, 258-259, 261-268 1.40
Arkansas: 716, 717, 719-723, 725 1.60 718, 724, 726-729 1.50	Indiana: 463-464 1.70 462, 465-466 1.40 460-461, 467-479 1.30	Nebraska: 680-681 1.30 682-693 1.20	Rhode Island: 1.50	Wisconsin: 532 1.60 531, 540, 543, 548 1.50 535, 537-539, 541, 542, 1.40 544-547, 549 1.40 530, 534 1.30
Colorado*: See State Specific Application	Iowa: 500-503 1.40 504-508, 510-516, 520-529 1.20	New Mexico: 870-875, 877-884 1.40	South Carolina: 1.50	Tennessee: 380-382 1.60 371-374 1.50 370, 377-379, 383-385 1.40 376 1.30
Delaware: 198 1.70 197 & 199 1.40	Maryland: 210-212, 214,215, 218 1.50 206, 208, 216, 217, 219 1.30 207, 209 1.30	North Carolina: 270-276, 280-282 1.40 277-279, 283-289 1.30	Texas*: See State Specific Application	Utah: 840-841, 844, 846 1.40 843, 845, 847 1.30
District Of Columbia* 200, 202-205 2.20	Michigan: 480-483 1.60 488-489 1.50 484, 485, 490-492, 497-499 1.40 486, 487, 493-496 1.30	Ohio: 440-441 1.60 436, 444-445 1.50 433-435, 437-439, 442-443, 1.40 446-447, 449, 452-453 1.40 430-432, 448, 450-451, 1.30 454-458 1.30	Virginia*: 222-223 1.90 220-221, 201 1.70 224-231, 232-239, 240-246 1.40	Wyoming: 820-831 1.40
Florida*: See State Specific Application	Georgia: 300-303 1.70 306, 313-314 1.60 308-309, 312 1.50 304-305, 307, 310-311, 1.40 315-319, 398 1.40	Oklahoma*: See State Specific Application		

*These states require the use of a state specific application form.

Plan is available in other states. Contact Allied for information.

RATES/AREAS EFFECTIVE 11/1/09

\$500 Deductible			\$1,000 Deductible			\$1,500 Deductible			\$2,500 Deductible		
Age	Male	Fem.	Age	Male	Fem.	Age	Male	Fem.	Age	Male	Fem.
0-29	\$48	\$57	0-29	\$42	\$49	0-29	\$35	\$41	0-29	\$29	\$34
30-34	\$55	\$69	30-34	\$48	\$60	30-34	\$40	\$50	30-34	\$33	\$41
35-39	\$66	\$83	35-39	\$57	\$71	35-39	\$48	\$59	35-39	\$39	\$48
40-44	\$79	\$96	40-44	\$68	\$82	40-44	\$56	\$68	40-44	\$46	\$55
45-49	\$96	\$108	45-49	\$82	\$93	45-49	\$68	\$76	45-49	\$55	\$62
50-54	\$122	\$130	50-54	\$104	\$111	50-54	\$86	\$91	50-54	\$69	\$74
55-59	\$168	\$156	55-59	\$143	\$133	55-59	\$117	\$109	55-59	\$94	\$88
60-64	\$225	\$207	60-64	\$192	\$176	60-64	\$157	\$144	60-64	\$125	\$116
Per Child	\$43		Per Child	\$37		Per Child	\$31		Per Child	\$26	
Supplemental Accident Rate			Supplemental Accident Rate			Supplemental Accident Rate			Supplemental Accident Rate		
Per Person.....	\$5		Per Person.....	\$5		Per Person.....	\$5		Per Person.....	\$5	

RATE LOAD FACTORS

EFFECTIVE DATE	PREPAY	MONTHLY
11/1/09 – 3/31/10	1.00	1.33
4/1/10 – 6/30/10	1.03	1.37
7/1/10 – 9/30/10	1.06	1.41
10/1/10 – 12/31/10	1.09	1.45
1/1/11 – 3/31/11	1.12	1.49

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:

- 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.
- 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.
- 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).

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

DISTRIBUTOR/GENERAL AGENT NAME: _____