



Medical Coverage Offered To Individuals and Families

Michigan Underwriting & Administrative Guidelines

These guidelines are in place in order to comply with health insurance legislation in Michigan and include the underwriting practices and procedures of Time Insurance Company. For state specific product information, refer to your product brochures and State Variations.

Enrollment: For those agents not using EASE, and applying for Standard Portfolio Plans, the following forms are required:

Distribution Channel	Paper Enrollment Form Number	Revision Date	Tele-App Part 1 Form Number included in Tele-App Packet	Revision Date	Tele-App Packet Form Number	Revision Date
RSD, MGA, RBG, NA, USAA & DSC	29300 (Rev. 2/2010)	New 9/2010	29400 (Rev. 2/2010)	New 9/2010	39400-MI-PKT	(Rev. 1/2011)
State Farm	29300 (Rev. 2/2010)	New 9/2010	29400 (Rev. 2/2010)	New 9/2010	29304-MI	(Rev. 1/2011)

For the most current version of the application forms listed above, as well as product brochures and State Variations, please refer to the Individual Medical option on Find A Form on the Agent Health Sales website at www.assuranthealthsales.com State Farm agents; please refer to the Assurant Health Sales Site.

Enrollment for Assurant Health Access Fixed-Indemnity Plans with Limited-Benefits: These plans may be quoted and submitted using EASE or manually quoted using rate sheets. For those agents not using EASE and applying for an Assurant Health Access Fixed- Indemnity Plan with Limited-Benefits, the following forms are required:

Distribution Channel	Assurant Health Access Enrollment Form	Revision Date	Rate Sheet Packet for Assurant Health Access Plans	Revision Date
RSD, MGA, NA, USAA & DSC	49800-MI	(Rev. 6/2011)	49901-MI-PKT	(Rev. 7/2011)
State Farm	49800-MI	(Rev. 6/2011)	49810-MI-KIT	(Rev. 7/2011)

For the most current version of the application forms listed above as well as product brochures, Assurant Health Access Fixed- Indemnity with Limited-Benefits Plan Rate Sheet Packets and State Variations, please refer to the Health Access option on Find A Form on the Assurant Health Agent Information website at www.assuranthealthsales.com.

Inforce Health Access Plan B or C enrollment form:

To service your clients with an existing Health Access Plan B or C, you should use the following forms available under the Health Access option on Find A Form:

Distribution Channel	Health Access Plan B or C Enrollment Form	Revision Date	Rate Sheet Packet for Health Access Plan B or C/Revision Date	Revision Date
RSD, MGA, RBG, NA, USAA & DSC	29800-MI	(Rev. 1/2010)	29801-MI-PKT	(Rev. 08/2010)

Health Replacement Form:

Assurant Health Access Fixed-Indemnity Plans with Limited-Benefits Internal Replacement Form:

If an applicant is replacing an existing Assurant Health medical plan with an Assurant Health Access Fixed- Indemnity Plan with Limited-Benefits, the Notice to Applicant Regarding Replacement of Comprehensive Medical Plan, Form 49802 must be completed. This form is available under the Health Access option on Find A Form.

Assurant Supplemental Coverage (ASC): These supplemental plans may be quoted and submitted using EASE or manually quoted using rate sheets. For those agents not using EASE, and applying for any of the Assurant Supplemental Plans available in your state, please refer to the Supplemental option on Find A Form on the Assurant Health Agent Information website at www.assuranthealthsales.com.

Eligibility: In order to be eligible for coverage, an individual must be a resident of Michigan, must be a member of the Health Advocates Alliance Association and must not have the coverage sponsored by a small employer. If a small employer is sponsoring coverage for any eligible employees as defined below, they are ineligible for this plan and should apply for a small group health plan. All individuals enrolling for coverage will be medically underwritten.

Standard Portfolio applications with a signed date of 7/17/2010 and later:

- No child only applications are allowed if all children are under 19.

Assurant Health Access Fixed- Indemnity Plans with Limited-Benefits:

- Child only applications are allowed for the Assurant Health Access Fixed- Indemnity Plans with Limited-Benefits.

Employer Sponsorship: We define employer sponsorship as meeting any one of the following criteria:

- Any portion of the premium or benefits is paid by or on behalf of the small employer.
- An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of a small employer for any portion of the premium.
- The health benefit plan is treated by the employer or any of the eligible employees as part of a plan or program for the purposes of Internal Revenue Code sections 106, 125, or 162.

A business payor is acceptable when the application has a billing mode of List Bill. When establishing a new List Bill Account, the List Bill Account Agreement Form 29237 is required as well as the List Bill Transmittal Form, Form 29236, for each application. Please refer to the Agent Administration Guide for List Bill, Form 29240, for additional details.

Employer Sponsored Business Questionnaire Form 29174 for Standard Portfolio Plans: is incorporated into the paper enrollment form 29300 (Rev. 2/2010). It is available as a stand alone employer sponsorship verification tool in the rate event that a separate form is needed.

Employer Sponsored Business Questionnaire Form 49808 for the Assurant Health Access Fixed-Indemnity Plans with Limited-Benefits: is incorporated into the enrollment form 49800-MI. It is available as a stand alone employer sponsorship verification tool in the rare event that a separate form is needed.

Neither of the Employer Sponsored Business Questionnaire Forms is required with the EASE or Tele-App process. Verification that coverage is not employer sponsored will be completed during the Personal Health History Interview.

Underwriting Actions Standard Portfolio Plans: Underwriting actions for our Standard Portfolio Plans may include the following and coverage may be issued with:

- preferred non-tobacco or preferred tobacco rates
- standard non-tobacco or standard tobacco rates.
- a special class premium.
- a condition specific deductible endorsement. *
- a special exception rider. The maximum duration a special exception rider can remain on a policy is 12 months. In order for a condition to be excluded, an individual must have had

medical advice, diagnosis, care or treatment received or recommended within 6 months of applying for coverage. The maximum duration of 12 months does not apply to hazardous activities. *

or

- Coverage may be declined based on medical history.***

* Not applicable to persons under the age of 19.

***Not applicable to persons under the age of 19 (with effective dates on or after 9/23/2010).

Underwriting Actions Assurant Health Access Fixed-Indemnity Plans with Limited-Benefits Plans:

- Coverage may be declined based on medical history and/or eligibility criteria.

Pre-existing Condition Limitation*: For most plans pre-existing conditions may be excluded up to 12 months following the effective date of coverage. A pre-existing condition is a sickness or injury and related complications for which medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a provider, or prescription drugs were prescribed during the 6-month period immediately prior to the covered person's effective date, regardless of whether the condition was diagnosed, misdiagnosed or not diagnosed; or a sickness, injury and related complications that produced signs or symptoms during the 6-month period immediately prior to the covered person's effective date; or a pregnancy existing on the day before the policy effective date.

Benefits are not paid for charges incurred due to a pre-existing condition until you have been continuously insured under the plan for up to 12 months, unless the condition was fully disclosed on the application. After the up to 12-month period, benefits are paid for a pre-existing condition, unless the condition is specifically excluded from coverage. Refer to product brochures and state variations for details.

*Not applicable to persons under the age of 19 on Standard Portfolio Plans (with effective dates on or after 9/23/2010).

Persons under 19 years of age are subject to Pre-existing limitations under the Assurant Health Access Fixed- Indemnity Plans with Limited-Benefits.

Continuity of Coverage Standard Portfolio Plans**: The pre-existing condition limitation period will not be applied if there is no gap in coverage between the termination date of the prior plan and the effective date of the Assurant plan and the prior qualifying coverage*** was in effect for a minimum of 6 months.

In order to provide continuity, we require that proof of prior qualifying coverage be submitted. Proof of prior qualifying coverage includes on or more of the following:

- A copy of the declarations,
- A summary of benefits or schedule page,

- A letter from the prior carrier indicating dates of coverage, type of coverage and names of those insured.

If proof of prior qualifying coverage is provided at a later date, we will provide continuity of coverage.

****Continuity of coverage** does not apply to our Assurant Health Access Fixed- Indemnity Plans with Limited-Benefits.

*****Qualifying Coverage:** Qualifying coverage is defined as coverage under a group health plan with a minimum duration of at least 6 months.

Preferred Rating Questionnaire Packet Form 26566-PKT: If submitting paper Enrollment Form 29300 (Rev. 2/2010), and applying for preferred rates, then the Preferred Rating Questionnaire Form 26566 must be completed and submitted. **Note:** Preferred Rating is not available with Assurant Health Access Fixed- Indemnity Plans with Limited-Benefits.

Form 26566 will not be required with the EASE or Tele-App process. Preferred Rating class eligibility will be verified during the Personal Health History Interview.

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA eligible individuals who wish to obtain coverage on a guaranteed issue basis with no pre-existing limitations, should apply for coverage through **Michigan Blue Cross/ Blue Shield at telephone 1-877-4my-blue (1-877-469-2583)**

HIPAA Eligible Individual: An eligible individual is a person who meets ALL of the following requirements:

- Has an aggregate period of creditable coverage of 18 months or more, with the most recent coverage being under a group health plan, government plan, or church plan.
- No gap in coverage or a gap of 63 days or less.
- Most recent coverage was not terminated due to nonpayment of premiums or fraud.
- Not eligible for coverage under a group health plan, Medicare, Medicaid, and does not have other health insurance coverage.
- Accepted and exhausted any available COBRA coverage or state continuation coverage.
- Not eligible for coverage under a group health plan, Medicare, Medicaid, and does not have other health insurance coverage.