



Viip (Vermont Individual Indemnity Plan)

Summary of Benefits

SERVICE CATEGORY	COVERAGE INFORMATION
Annual Deductible	You choose a \$3,500, \$5,000, \$10,000, \$25,000 or \$100,000 deductible. Services are covered as noted below after satisfaction of the annual deductible.
Coinsurance	Varies with service, please see your Subscriber Contract for more details.
Calendar Year Maximum Benefit	\$250,000 per individual per calendar year
Lifetime Maximum Benefit Payable	\$1,000,000 per individual
Hospital	
Hospital Inpatient	MVP covers at 100% of allowable charges ¹
Hospital Outpatient-Ambulatory Surgery	MVP covers at 70% of allowable charges ¹
Physician Office Visits	
Coverage available only for treatment of illness, injury or condition.	
Physician Inpatient Care (Medical/Surgical)	
Second Opinion-Surgery/Cancer (Optional)	
Maternity	
Physician Services	MVP covers at 100% of allowable charges
Hospital Services	
Nursery Care	
Outpatient Physical/Occupational/Speech Therapy (Combined 60 visits/year max.)	
Ambulance	
Home Health Care (40 visits/year max.)	
Skilled Nursing Facility (30 consecutive days/year max.)	
Mammography Screening	
Diagnostic Lab and X-Ray ¹	MVP covers at 70% of allowable charges
Emergency Outpatient Hospital Care	
Durable Medical Equipment	MVP covers at 100% of allowable charges ¹ (Lifetime max. benefit \$25,000 per individual)
Mental Health	
Inpatient	
Outpatient	MVP covers at 100% of allowable charges ¹ (must use preferred providers)
Substance Abuse	
Detoxification, Inpatient and Outpatient Rehabilitation	
Prescription Drug Benefit ²	Subject to \$250 deductible, 50% coinsurance, calendar year max. benefit \$5,000 per individual. Subject to MVP formulary. Must use participating pharmacies.

Note: Benefits are subject to a pre-existing condition provision for 12 months, if applicable.

Allowable charges means the maximum benefit available. The allowable charge is established by MVP in accordance with a Fee Agreement; Usual, Customary and Reasonable Charges; or by law. Please see your Subscriber Contract for more details.

¹Member is required to contact MVP for pre-certification prior to obtaining these services. If pre-certification is not obtained, coverage is reduced by \$300. Additionally, if we conduct Retrospective Review and determine that any admission and/or service(s) were not medically necessary, we will not provide benefits.

²Certain prescription drugs require Prior Approval before dispensing. As a guide, visit www.mvphealthcare.com, look under Rx Info, and see the Prescription Drug Formulary chart. Drugs listed with the “#” indicator require Prior Approval.

This is a summary description only. Limitations and exclusions may apply. Please see your Subscriber Contract for details. In the event of any conflict between this document and your Subscriber Contract, your Subscriber Contract shall be controlling.

Features and Benefits

Benefits

- Worldwide emergency coverage
- Complete hospital coverage – no day or dollar limits

Additional Features

- *MVP 24/7 Nurseline* – reach our Member Services Department every day 8 a.m. to 10 p.m., **1-888-MVP-MBRS (1-888-687-6277)**
- Visit our innovative Web site at **www.mvphealthcare.com** that offers many convenient features:
 - Ask a question about coverage
 - Check claim status, eligibility and benefits
 - Change your address
- Exclusive member discounts on health and safety items, health clubs, optical programs, etc.
- A variety of special education programs for expectant mothers and families... and more!

Web Tools and Services

*To help your employees make informed health care decisions – find these tools in the Health Central section at **www.mvphealthcare.com**.*

- Online health library – powered by Healthwise® Knowledgebase
- Hospital quality comparison tool
- Hospital quality profiles
- Wide range of disease and care management programs

ViiP Rate Quote Table and Instructions

If you need assistance calculating your rate, call the program administrator at 800-635-7801

1. **Choose your deductible.** Refer to the Quote Table (see next page) for the month you wish coverage to start. Determine your plan design based on the deductible level you'd like to purchase and check the "Deductible Level" box at the bottom of the form. Note which column this is; you will use this in Step 3 (and 4-5, if applicable).
2. **Determine your age on the Policy Effective Date.** If your birthday falls between today and the Policy Effective Date, increase your age today by one year. Note this age in the Quote Table on the bottom of the page in the "Age" column on the "Subscriber" row.
3. **Enter your monthly rate.** Locate your age from Step 2 on the Quote Table. Match that column with your chosen deductible level. Enter this amount in the Quote Table on the bottom of the page on the "Subscriber" row of the column you chose in Step 1. If you are the only one covered on your policy, proceed to Step 6.
4. **(If applicable) Enter your spouse's/domestic partner's monthly premium.** Determine the age of your spouse or partner on the Policy Effective Date in the same way you determined yours in Step 2. Locate your spouse's or domestic partner's age on the Quote Table. Match that column with your chosen deductible level. Enter this amount in the Quote Table on the bottom of the page on the "Spouse/DomPar" row of the column you chose in Step 1.
5. **(If applicable) Enter the monthly premium for your dependent(s).** Each dependent child has the same rate. Locate the "Dependent Child" category on the Quote Table. Enter this amount in the Quote Table on the bottom of the page on the "Dependent" row of the column you chose in Step 1 for each dependent you wish to cover.
6. **Add up your Total Monthly Rate.** Total the sum of the rates noted in the column(s) for "Subscriber," "Spouse/DomPar" (if applicable) and "Dependents" (if applicable). This is your total monthly premium.
7. **Sign, date, and return with your ViiP enrollment materials.** Sign this rate sheet, keep a copy for yourself, and return this rate sheet, completed enrollment form, and a check for the first month's total monthly premium calculated in Step 6 and mail to the address below. **This must be postmarked by the 15th of the month in order for coverage to begin on the first of the following month.** Premium rate quotes change monthly. (If the application package is not postmarked by the 15th of the month, you will need to request a new ViiP Rate Quote Table.)
8. **Make check payable to MVP Health Care and mail, along with completed enrollment materials, to the program administrator:** Meyer and Associates, 18 Washington Avenue, Chatham, NJ 07928.

Please Note:

In order to comply with the Federal Patient Protection and Affordable Care Act, MVP is filing new rates and forms with the Department of Banking, Insurance, Securities and Health Care Administration (BISCHA) which have not been approved. We will update the rate table with the actual rates for new policies upon approval from BISCHA.



ViiP Rate Quote Table

Renewal Rates Only
 POLICY EFFECTIVE DATE: OCTOBER 1, 2010

If you need assistance calculating your rate, contact the administrator at 800-635-7801

Deductible		\$3,500	\$5,000	\$10,000	\$25,000	\$100,000
Age on Policy Effective Date		Monthly Premium per Covered Adult				
Dependent Child		\$104.20	\$88.43	\$70.67	\$28.66	\$7.75
Under 30		\$222.28	\$188.68	\$150.77	\$61.13	\$16.53
30		\$225.03	\$191.00	\$152.63	\$61.89	\$16.73
31		\$227.82	\$193.36	\$154.52	\$62.66	\$16.94
32		\$230.64	\$195.75	\$156.42	\$63.44	\$17.13
33		\$233.49	\$198.18	\$158.35	\$64.22	\$17.34
34		\$236.36	\$200.64	\$160.30	\$65.01	\$17.57
35		\$239.29	\$203.11	\$162.29	\$65.80	\$17.79
36		\$242.25	\$205.63	\$164.30	\$66.63	\$18.00
37		\$245.23	\$208.19	\$166.34	\$67.44	\$18.23
38		\$248.28	\$210.77	\$168.39	\$68.28	\$18.45
39		\$251.35	\$213.38	\$170.47	\$69.13	\$18.66
40		\$254.45	\$216.01	\$172.57	\$69.97	\$18.90
41		\$257.60	\$218.70	\$174.72	\$70.84	\$19.14
42		\$260.77	\$221.41	\$176.87	\$71.72	\$19.38
43		\$264.00	\$224.14	\$179.06	\$72.61	\$19.61
44		\$267.25	\$226.91	\$181.28	\$73.51	\$19.85
45		\$270.56	\$229.71	\$183.51	\$74.41	\$20.10
46		\$273.90	\$232.54	\$185.77	\$75.32	\$20.35
47		\$277.29	\$235.42	\$188.08	\$76.25	\$20.59
48		\$280.72	\$238.33	\$190.40	\$77.19	\$20.85
49		\$284.20	\$241.28	\$192.77	\$78.15	\$21.10
50		\$287.70	\$244.26	\$195.14	\$79.11	\$21.37
51		\$291.27	\$247.29	\$197.55	\$80.10	\$21.64
52		\$294.86	\$250.34	\$199.99	\$81.09	\$21.91
53		\$298.52	\$253.43	\$202.45	\$82.09	\$22.17
54		\$302.21	\$256.56	\$204.95	\$83.10	\$22.44
55		\$305.94	\$259.74	\$207.49	\$84.12	\$22.72
56		\$309.71	\$262.96	\$210.06	\$85.16	\$23.01
57		\$313.54	\$266.21	\$212.66	\$86.21	\$23.29
58		\$317.42	\$269.50	\$215.28	\$87.28	\$23.58
59		\$321.33	\$272.84	\$217.95	\$88.37	\$23.88
60		\$325.30	\$276.21	\$220.63	\$89.45	\$24.18
61		\$329.33	\$279.63	\$223.36	\$90.56	\$24.48
62		\$333.39	\$283.09	\$226.11	\$91.67	\$24.78
63		\$333.39	\$283.09	\$226.11	\$91.67	\$24.78
64+		\$333.39	\$283.09	\$226.11	\$91.67	\$24.78

My Premium: \$3,500 \$5,000 \$10,000 \$25,000 \$100,000
 Check Deductible Level

My Premium:	AGE	RATE	RATE	RATE	RATE	RATE
Subscriber						
Spouse/DomPar						
Dependent						
Dependent						
Dependent						
Total Monthly Rate						

 Print Name

 Signature

 Date



ViiP Rate Quote Table POLICY EFFECTIVE DATE: NOVEMBER 1, 2010

If you need assistance calculating your rate, contact the administrator at 800-635-7801

Deductible		\$3,500	\$5,000	\$10,000	\$25,000	\$100,000
Age on Policy Effective Date		Monthly Premium per Covered Adult				
Dependent Child		\$104.20	\$88.43	\$70.67	\$28.66	\$7.75
Under 30		\$222.28	\$188.68	\$150.77	\$61.13	\$16.53
30		\$225.03	\$191.00	\$152.63	\$61.89	\$16.73
31		\$227.82	\$193.36	\$154.52	\$62.66	\$16.94
32		\$230.64	\$195.75	\$156.42	\$63.44	\$17.13
33		\$233.49	\$198.18	\$158.35	\$64.22	\$17.34
34		\$236.36	\$200.64	\$160.30	\$65.01	\$17.57
35		\$239.29	\$203.11	\$162.29	\$65.80	\$17.79
36		\$242.25	\$205.63	\$164.30	\$66.63	\$18.00
37		\$245.23	\$208.19	\$166.34	\$67.44	\$18.23
38		\$248.28	\$210.77	\$168.39	\$68.28	\$18.45
39		\$251.35	\$213.38	\$170.47	\$69.13	\$18.66
40		\$254.45	\$216.01	\$172.57	\$69.97	\$18.90
41		\$257.60	\$218.70	\$174.72	\$70.84	\$19.14
42		\$260.77	\$221.41	\$176.87	\$71.72	\$19.38
43		\$264.00	\$224.14	\$179.06	\$72.61	\$19.61
44		\$267.25	\$226.91	\$181.28	\$73.51	\$19.85
45		\$270.56	\$229.71	\$183.51	\$74.41	\$20.10
46		\$273.90	\$232.54	\$185.77	\$75.32	\$20.35
47		\$277.29	\$235.42	\$188.08	\$76.25	\$20.59
48		\$280.72	\$238.33	\$190.40	\$77.19	\$20.85
49		\$284.20	\$241.28	\$192.77	\$78.15	\$21.10
50		\$287.70	\$244.26	\$195.14	\$79.11	\$21.37
51		\$291.27	\$247.29	\$197.55	\$80.10	\$21.64
52		\$294.86	\$250.34	\$199.99	\$81.09	\$21.91
53		\$298.52	\$253.43	\$202.45	\$82.09	\$22.17
54		\$302.21	\$256.56	\$204.95	\$83.10	\$22.44
55		\$305.94	\$259.74	\$207.49	\$84.12	\$22.72
56		\$309.71	\$262.96	\$210.06	\$85.16	\$23.01
57		\$313.54	\$266.21	\$212.66	\$86.21	\$23.29
58		\$317.42	\$269.50	\$215.28	\$87.28	\$23.58
59		\$321.33	\$272.84	\$217.95	\$88.37	\$23.88
60		\$325.30	\$276.21	\$220.63	\$89.45	\$24.18
61		\$329.33	\$279.63	\$223.36	\$90.56	\$24.48
62		\$333.39	\$283.09	\$226.11	\$91.67	\$24.78
63		\$333.39	\$283.09	\$226.11	\$91.67	\$24.78
64+		\$333.39	\$283.09	\$226.11	\$91.67	\$24.78

My Premium: \$3,500 \$5,000 \$10,000 \$25,000 \$100,000
 Check Deductible Level

My Premium:	AGE	RATE	RATE	RATE	RATE	RATE
Subscriber						
Spouse/DomPar						
Dependent						
Dependent						
Dependent						
Total Monthly Rate						

Print Name

Signature

Date



ViiP Rate Quote Table POLICY EFFECTIVE DATE: DECEMBER 1, 2010

If you need assistance calculating your rate, contact the administrator at 800-635-7801

Deductible		\$3,500	\$5,000	\$10,000	\$25,000	\$100,000
Age on Policy Effective Date		Monthly Premium per Covered Adult				
Dependent Child		\$104.20	\$88.43	\$70.67	\$28.66	\$7.75
Under 30		\$222.28	\$188.68	\$150.77	\$61.13	\$16.53
30		\$225.03	\$191.00	\$152.63	\$61.89	\$16.73
31		\$227.82	\$193.36	\$154.52	\$62.66	\$16.94
32		\$230.64	\$195.75	\$156.42	\$63.44	\$17.13
33		\$233.49	\$198.18	\$158.35	\$64.22	\$17.34
34		\$236.36	\$200.64	\$160.30	\$65.01	\$17.57
35		\$239.29	\$203.11	\$162.29	\$65.80	\$17.79
36		\$242.25	\$205.63	\$164.30	\$66.63	\$18.00
37		\$245.23	\$208.19	\$166.34	\$67.44	\$18.23
38		\$248.28	\$210.77	\$168.39	\$68.28	\$18.45
39		\$251.35	\$213.38	\$170.47	\$69.13	\$18.66
40		\$254.45	\$216.01	\$172.57	\$69.97	\$18.90
41		\$257.60	\$218.70	\$174.72	\$70.84	\$19.14
42		\$260.77	\$221.41	\$176.87	\$71.72	\$19.38
43		\$264.00	\$224.14	\$179.06	\$72.61	\$19.61
44		\$267.25	\$226.91	\$181.28	\$73.51	\$19.85
45		\$270.56	\$229.71	\$183.51	\$74.41	\$20.10
46		\$273.90	\$232.54	\$185.77	\$75.32	\$20.35
47		\$277.29	\$235.42	\$188.08	\$76.25	\$20.59
48		\$280.72	\$238.33	\$190.40	\$77.19	\$20.85
49		\$284.20	\$241.28	\$192.77	\$78.15	\$21.10
50		\$287.70	\$244.26	\$195.14	\$79.11	\$21.37
51		\$291.27	\$247.29	\$197.55	\$80.10	\$21.64
52		\$294.86	\$250.34	\$199.99	\$81.09	\$21.91
53		\$298.52	\$253.43	\$202.45	\$82.09	\$22.17
54		\$302.21	\$256.56	\$204.95	\$83.10	\$22.44
55		\$305.94	\$259.74	\$207.49	\$84.12	\$22.72
56		\$309.71	\$262.96	\$210.06	\$85.16	\$23.01
57		\$313.54	\$266.21	\$212.66	\$86.21	\$23.29
58		\$317.42	\$269.50	\$215.28	\$87.28	\$23.58
59		\$321.33	\$272.84	\$217.95	\$88.37	\$23.88
60		\$325.30	\$276.21	\$220.63	\$89.45	\$24.18
61		\$329.33	\$279.63	\$223.36	\$90.56	\$24.48
62		\$333.39	\$283.09	\$226.11	\$91.67	\$24.78
63		\$333.39	\$283.09	\$226.11	\$91.67	\$24.78
64+		\$333.39	\$283.09	\$226.11	\$91.67	\$24.78

My Premium: \$3,500 \$5,000 \$10,000 \$25,000 \$100,000
 Check Deductible Level

My Premium:	AGE	RATE	RATE	RATE	RATE	RATE
Subscriber						
Spouse/DomPar						
Dependent						
Dependent						
Dependent						
Total Monthly Rate						

Print Name

Signature

Date



MVP Health Insurance Company
 HEADQUARTERS
 625 State Street, P.O. Box 2207
 Schenectady, NY 12301-2207
 518-370-4793 · 1-800-777-4793

ADMINISTRATOR: Meyer and Associates
 18 Washington Ave. · Chatham, NJ 07928
 800-635-7801

MVP ViIP (Vermont Individual Indemnity Plan) Enrollment/Change Form

INSTRUCTIONS: Please print or type and complete Sections 1 - 9

1 PLEASE PROVIDE US WITH INFORMATION ABOUT YOURSELF

Applicant Name (Last, First, Initial, Suffix) _____ Sex M F

Address _____ City _____ State _____ Zip _____ County _____

Mailing Address for Premium Notices (if different from above) _____ City _____ State _____ Zip _____ County _____

Social Security # _____ Home Phone _____ Business Phone _____ Email Address _____

Marital Status Single Married Widowed Separated Spouse's health insurance ID# _____

Eligible for Medicare? Applicant ID# _____ Spouse ID# _____

Please provide Certificates of Creditable Coverage or other means of proof. Other means of proof which may be submitted include explanation of benefits, correspondence from the plan indicating coverage, pay stubs showing a payroll deduction for health coverage or a health insurance identification card.

Applicant A Effective Date _____ B Effective Date _____ Spouse A Effective Date _____ B Effective Date _____

2 PLEASE INDICATE ENROLLMENT/CHANGE For address changes, call 1-888-687-6277

A New Applicant Name Change Add Dependent Termination Remove Dependent(s) only (please specify) _____

Reason: _____ Moved From Area Opting for Other Coverage Other _____

3 PLEASE CHOOSE YOUR DEDUCTIBLE AND PREFERRED EFFECTIVE DATE

Deductible: \$3,500 \$5,000 \$10,000 \$25,000 \$100,000 Requested Effective Date of Coverage (Month/Day/Year) _____

Your coverage will be effective on the first day of the month you choose.

4 PLEASE PROVIDE THE FOLLOWING INFORMATION FOR ALL FAMILY MEMBERS YOU WANT ENROLLED UNDER YOUR PLAN

Relationship to Applicant	Name First, MI, Last	Date of Birth MM/DD/YY	Social Security Number	Check if Student Over 18	Check if Disabled
Self <input type="checkbox"/> M <input type="checkbox"/> F	_____	____/____/____	____/____/____		
<input type="checkbox"/> Spouse	_____	____/____/____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	____/____/____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	____/____/____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	____/____/____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>

NOTE: With the exception of your spouse, each dependent must be under 19 years of age, or a full-time student under age 25, or have a disability waiver - attached if necessary. **To obtain a waiver, call MVP.**

ViIP is MVP's Vermont Non-group Indemnity Plan offered by MVP Health Insurance Company

ViIP ENROLLMENT FORM

5 PRE-EXISTING CONDITION INFORMATION

1. During the past 12 months, has any person proposed for insurance ever received medical care for or had (check all that apply):
- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Liver Disorder | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervous Disorder |
| <input type="checkbox"/> Digestive Disorder | <input type="checkbox"/> Back Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tumor | <input type="checkbox"/> Anemia | <input type="checkbox"/> Prostate Disorder | <input type="checkbox"/> Respiratory Disorder |
- None of these**
2. During the past 12 months, have you been treated or diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) by a licensed medical physician? Yes No
3. During the past 12 months, other than shown in #1 above, has any person proposed for insurance (check all that apply):
- | | | |
|---|--|--|
| <input type="checkbox"/> Sought or been advised to seek treatment for any illness or injury | <input type="checkbox"/> Had surgery | <input type="checkbox"/> Had a medical examination or medical care |
| <input type="checkbox"/> Been hospitalized | <input type="checkbox"/> None of these | |

6 OTHER COVERAGE INFORMATION

Do you, your spouse or any named dependent already have or are applying for hospital, disability, major medical, HMO or dental coverage with another company? Yes No

Indicate Plans in Force During the Last 12 Months. Please provide Certificates of Creditable Coverage or other means of proof which may be submitted include explanation of benefits, correspondence from the plan indicating coverage, pay stubs showing a payroll deduction for health coverage or a health insurance identification card.

Type of Coverage: <input type="checkbox"/> Major Med <input type="checkbox"/> Major Hosp <input type="checkbox"/> HMO <input type="checkbox"/> Disability <input type="checkbox"/> Dental <input type="checkbox"/> Medicaid <input type="checkbox"/> CHAMPUS/TRICARE <input type="checkbox"/> Child Health Plus	Name _____	Policy Certificate # _____	Issue Date _____	Paid To-Date _____
Company or Association and Address _____				
List Deductible, Maximum Amount, Elimination Period, Benefits, Benefit Period, etc. _____				
Type of Coverage: <input type="checkbox"/> Major Med <input type="checkbox"/> Major Hosp <input type="checkbox"/> HMO <input type="checkbox"/> Disability <input type="checkbox"/> Dental <input type="checkbox"/> Medicaid <input type="checkbox"/> CHAMPUS/TRICARE <input type="checkbox"/> Child Health Plus	Name _____	Policy Certificate # _____	Issue Date _____	Paid To-Date _____
Company or Association and Address _____				
List Deductible, Maximum Amount, Elimination Period, Benefits, Benefit Period, etc. _____				
Type of Coverage: <input type="checkbox"/> Major Med <input type="checkbox"/> Major Hosp <input type="checkbox"/> HMO <input type="checkbox"/> Disability <input type="checkbox"/> Dental <input type="checkbox"/> Medicaid <input type="checkbox"/> CHAMPUS/TRICARE <input type="checkbox"/> Child Health Plus	Name _____	Policy Certificate # _____	Issue Date _____	Paid To-Date _____
Company or Association and Address _____				
List Deductible, Maximum Amount, Elimination Period, Benefits, Benefit Period, etc. _____				
Type of Coverage: <input type="checkbox"/> Major Med <input type="checkbox"/> Major Hosp <input type="checkbox"/> HMO <input type="checkbox"/> Disability <input type="checkbox"/> Dental <input type="checkbox"/> Medicaid <input type="checkbox"/> CHAMPUS/TRICARE <input type="checkbox"/> Child Health Plus	Name _____	Policy Certificate # _____	Issue Date _____	Paid To-Date _____
Company or Association and Address _____				
List Deductible, Maximum Amount, Elimination Period, Benefits, Benefit Period, etc. _____				

7 AUTHORIZATION

On behalf of myself and any listed dependents, I (we) hereby apply for membership in MVP. I understand that benefits provided under MVP's Healthy NY, HMO, Indemnity, PPO, and EPO plans may be subject to preexisting condition limitations.

I hereby authorize any licensed physician, hospital or other health care provider to furnish MVP with such medical information about myself and my minor eligible dependents listed on the application that may be required to allow MVP to administer my benefits. This authorization excludes the release of any information about previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC.

I hereby certify that the statements made are true and complete to the best of my knowledge and belief.

7 AGREEMENTS

I, the undersigned, agree that all answers in the application: (a) are true and complete to the best of my knowledge and belief and (b) will be relied on to determine insurability and (c) which are incorrect for misleading, may void the application effective the issue date.

No Agent/Producer can: (a) waive or change any receipt; or (b) agree to issue a Subscriber Contract. I have: (a) read the Agreements section and (b) read and approved the answers as recorded.

4. Are you or any person in your immediate family pregnant? Yes No
If "Yes", give anticipated delivery date _____ and _____

Doctor's name _____

5. Complete the following to expand upon all affirmative answers above.

Name _____	Condition(s) _____
Name _____	Condition(s) _____
Name _____	Condition(s) _____
Name _____	Condition(s) _____
Name _____	Condition(s) _____
Name _____	Condition(s) _____

7 SIGNATURES

Signature of Applicant _____

Signature of Spouse (if a Proposed Dependent) _____

I/We certify that during an in-person interview with the Proposed Insured(s), I/We asked each question exactly as written and recorded the answers provided by the Proposed Applicant/Dependent(s) completely and accurately. Yes No

Signature of Agent/Producer _____ Office Address _____
Meyer and Associates 18 Washington Ave. Chatham, NJ 07928

Agent/Producer's License/ID Number _____

Signature of Agent/Producer _____

Office Name _____ Office Address _____

Agent/Producer's License/ID Number _____