



AIM Xtra Hospital & Critical Illness Rider

SMART CHOICE FOR INCREASING HOSPITAL AND CRITICAL ILLNESS COVERAGE

HOSPITAL BENEFIT

The plan pays on an Indemnity basis \$500 per day in the hospital for 31 days per calendar year. Plan also pays an additional \$500 per day if the insured is in ICU or CCU for an additional 31 days per calendar year. These benefits and amounts are in addition to any other benefits received by the policy.

CRITICAL ILLNESS BENEFIT

- **\$25,000 One Time Benefit**
- The insurance carrier (A.I.G) will pay one time benefit of \$25,000 for the diagnosis of a critical illness.
- Family coverage will cover both the primary insured and their spouse.
- Pre-existing conditions are covered after 12 consecutive months of coverage.
- The policy has 10 Critical Illnesses that are covered. (**please see next page**)

Call: Martin Unger (800) 986-4786 email: getaquote@gmail.com

MONTHLY RATES	
Employee	\$ 88.00
Employee + 1	\$ 155.50
Family	\$ 175.00

CRITICAL ILLNESS



The Need for Critical Illness Insurance

All AIM members that enroll into **AIM Xtra Rider** will have a \$25,000 Critical Illness Benefit

Coverage

Critical Illness Diagnosis

If an insured person is diagnosed with a critical illness, listed below, by a physician, the Company will pay a benefit subject to the Benefit Payment Conditions and Schedule of Benefits of the plan selected. Once a 100% of the maximum benefit amount has been paid for an insured person, coverage terminates and no further benefits are payable to that insured person.

Life Threatening Cancer

Pays benefits if an insured person is first diagnosed with life threatening cancer, more than 90 after the person's effective date of coverage. (The benefit is 10% payment after 30 days and before 90 days.)

Heart Attack

Pays benefits if an insured person is first diagnosed as having suffered a heart attack more than 30 days after the person's effective date of coverage.

Kidney (Renal) Failure

Pays benefits if an insured person is first diagnosed with having suffered kidney (renal) failure more than 30 days after the person's effective date of coverage.

Stroke

Pays benefits if an insured person is first diagnosed with having suffered a stroke more than 30 days after the person's effective date of coverage.

Coma

Pays benefits if an insured person is first diagnosed as being comatose more than 30 days after the person's effective date of coverage.

Coronary Artery Bypass Graft

Pays 25% of the benefit amount if an insured person is first diagnosed with a condition that necessitates a Coronary Artery Bypass Graft and receives the Coronary Artery Bypass Graft more than 30 days after the person's effective date of coverage. This benefit is paid once per lifetime.

Loss of Sight, Speech or Hearing

Loss of Sight, Speech or Hearing Pays benefits if an insured person is first diagnosed with loss of Sight, speech or Hearing more than 30 days after the person's effective date of coverage.

Major Organ Transplant

Pays benefits if an insured person is first diagnosed with a condition that necessitates a Major Organ Transplant and receives that Major Organ Transplant more than 30 days after the person's effective date of coverage.

Paralysis

Pays benefits if an insured person is first diagnosed as being paralyzed more than 30 days after the person's effective date of coverage.

Severe Burns

Pays benefits, depending on the severity of the burn, if an insured person is first diagnosed with having suffered a Severe Burn more than 30 days after the person's effective date of coverage.

These are brief descriptions of the coverage available under the policy. The policies will contain limitations, exclusions and termination provisions

AIM Xtra ENROLLMENT APPLICATION

OFFICE USE ONLY:

To be completed by Contract Group (AIM)

Name of Group:		Group Number:		
Effective Date:	Date Submitted:	Approved By:	Processed By:	Date Processed:

SECTION I — Enrollment Form - FORM MUST BE FILLED OUT IN BLACK BALLPOINT INK - PLEASE PRINT CLEARLY

APPLICATION TYPE (Check Appropriate Box) ENROLLMENT ENROLLMENT CHANGE TERMINATION

LEVEL OF COVERAGE (Check Appropriate Box) SUBSCRIBER SUBSCRIBER PLUS ONE SUBSCRIBER PLUS TWO OR MORE

SELECT MEDICAL PLAN (Check Appropriate Box) AIM Xtra Rider

APPLICANT NAME (Last, First, Middle Initial)		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	REQUESTED EFFECTIVE DATE FIRST DAY of (MM/YYYY)	
STREET ADDRESS		CITY	STATE	SOCIAL SECURITY NUMBER
BILLING ADDRESS / CONTACT / COMPANY (If different than above)			EMAIL ADDRESS	
HOME TELEPHONE	WORK TELEPHONE	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		DATE of EVENT (If Applicable)
TERM LIFE BENEFICIARY		RELATIONSHIP to APPLICANT		
EMERGENCY CONTACT (Name)	RELATION	CONTACT NUMBER	ALTERNATE CONTACT NUMBER	

Note: If you are applying for coverage for your spouse and/or children, please list each one below - see Election of Coverage for eligibility. Please indicate additional dependents on a duplicate sheet.

LAST NAME	FIRST NAME	RELATIONSHIP	GENDER	SOCIAL SECURITY NUMBER	BIRTHDATE (mm/dd/yyyy)	Check if over 19 & disabled?	TERM LIFE BENEFICIARY
SPOUSE		<input type="checkbox"/> WIFE <input type="checkbox"/> HUSBAND	<input type="checkbox"/> Male <input type="checkbox"/> Female				
DEPENDENT		<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> Male <input type="checkbox"/> Female				
DEPENDENT		<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> Male <input type="checkbox"/> Female				
DEPENDENT		<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> Male <input type="checkbox"/> Female				
DEPENDENT		<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> Male <input type="checkbox"/> Female				

Are you covered by any other health insurance plan? YES NO (If yes indicate below) Is your spouse covered by any other health insurance plan? YES NO (If yes indicate below)

INSURANCE COMPANY NAME	POLICY NUMBER	INSURANCE COMPANY NAME	POLICY NUMBER
ADDRESS	EFFECTIVE DATE	ADDRESS	EFFECTIVE DATE

ELECTION OF COVERAGE AND AUTHORIZATION*

The applicant in consideration of membership in the Association and participation in the plan hereby acknowledges that the Association, its third party administrator, their agents, owners, successors and assigns assumes no liabilities or obligations other than those specifically identified. I hereby agree to indemnify them from and against any and all claims, damages, losses, costs or expenses (including, without limitation, attorneys fees and disbursements) for any claims that may arise by the participation of the plan or membership in the association. I understand that pre-existing conditions will not be covered during the first 12 months of the contract unless I present evidence of prior creditable coverage. All information provided above is true and complete to the best of my knowledge. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, shall be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation. **Disclaimer IMPORTANT!** Our medical plan is a low-cost alternative, providing medical insurance at fixed amounts, and these **limited benefits** are paired with medical discounts to designated providers. My signature below indicates that the limitations of the plan have been disclosed & explained to me and that I understand and accept said plan designs. My signature below also indicates I would like to enroll in the limited medical health plan I selected above. All applicants must sign below. Any false statement will be cause for immediate cancellation of coverage. **It will take one week after your effective date for your cards and provider books to arrive.**

APPLICANT SIGNATURE (REQUIRED) X	DATE
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ACCEPTANCE AND AGREEMENT NOTICE: Submission of Employer Application does not initiate coverage. Coverage is subject to approval prior to initiation. Enrollees will be issued individual policies and/or certificates of insurance. Minimum participation may be required. In the event that participation is not met, coverage will not take effect. Your coverage will begin on the first day of the month following receipt of the Enrollment Form. This is a limited benefit policy and is not a substitute for a major medical plan.

APPLICANT SIGNATURE (REQUIRED) X	PRINT NAME	DATE
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AIM XTRA — Limited Benefit Hospital Plan with Critical Illness
ENROLLMENT FORM (PAGE 2)

Rep Name: Lisa Unger	Rep Signature X	Date	Telephone:	Rep Code: LU-5460
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SECTION IV — BILLING FORM - FORM MUST BE FILLED OUT IN BLACK BALLPOINT INK - PLEASE PRINT CLEARLY

<p>SELECT MONTHLY PREMIUM</p> <p>Individual Only <input type="checkbox"/> AIM Xtra \$88.00</p> <p>Individual Plus One <input type="checkbox"/> \$155.50</p> <p>Family <input type="checkbox"/> \$175.00</p>	<p>CALCULATE MONTHLY PREMIUM</p> <p>Step 1. Enter Premium Selected: \$ _____</p> <p>Step 2. One Time Enrollment Fee: \$25.00</p> <p>Step 3. Total Contribution at Enrollment — Add Steps 1 & 2 \$ _____</p>
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PAYMENT OPTIONS (Check Appropriate Box Below)

- CHECK OR MONEY ORDER (**Make payable to Insurance Resource Group. There is a \$30 insufficient funds fee**)
- INITIAL PAYMENT:** I will pay my 1st month's premium, admin fee, association dues and one time enrollment fee **via check/money order**. My check/money order is enclosed with the Enrollment Form.
- MONTHLY PAYMENT:** Send me a monthly invoice to pay my monthly premium, admin fee and association dues. I agree to pay an **additional fee of \$10** to receive a monthly invoice.
- ELECTRONIC FUNDS TRANSFER (**Fill out EFT Authorization Form below and include a legible voided check.**)
- INITIAL PAYMENT:** EFT my bank account for 1st month's premium, admin fee, association dues and one time enrollment fee. EFT occurs between the 15th and 20th of the month prior to the effective date.
- MONTHLY PAYMENT:** EFT my bank account for the monthly premium, admin fee and association dues. EFT occurs between the 15th and 20th of the month prior to the next months coverage.

I understand this authority is to remain in full force and in effect until IRG has received written notification from me of its termination in such time and such manner as to afford IRG and depositor a reasonable opportunity to act on it. I have the right to stop payment of a debit entry (deduction) by notification to IRG three business days or more before this payment is scheduled to be made. Please be aware that your bank statement will reflect the debit as IRG-HEALTH.

APPLICANT SIGNATURE (REQUIRED) X	PRINT NAME	DATE
ACCOUNT HOLDER SIGNATURE (REQUIRED if paying via EFT) X	PRINT NAME	DATE

EFT AUTHORIZATION FORM — FORM MUST BE FILLED OUT IN BLACK BALLPOINT INK - PLEASE PRINT CLEARLY

BANK NAME	BANK ROUTING NUMBER	BANK ACCOUNT NUMBER
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Mail To:

Martin Unger
5070 NW 96th Way
Coral Springs, FL 33076

Fax: 1-775-254-2881

Voided check is required and must be legible. No monthly charge for EFT.

PLEASE ATTACH A CHECK MARKED

VOID

TO ENSURE ACCURACY