IAC Personal Health Plans

Simple Solutions for Individuals and Families

Producer Guide

Administered and Marketed by:

Underwritten by:

The information in this Producer Guide is of general nature and may not contain state specific variations. Please consult the Certificate of Coverage, Schedule of Benefits and Riders for additional details.

This Producer Guide contains a brief description of the plan requirements. It is neither a contract nor a part of the policy. The exact provisions governing the insurance contract are contained in the Policy. For full details, consult the Policy/Certificate of Insurance. This plan may not be available in all states. Please check with your IAC General Agent regarding availability. Some provisions, benefits, exclusions or limitations listed herein may vary depending on state of residence.

Using the Producer Guide

Thank you for your interest in our products. This guide contains important information concerning the insuring carrier's business processing and underwriting guidelines. The procedures contained herein are designed to help you determine eligibility of individuals and help facilitate the prompt review and processing of your business. Throughout this document, writing agents will be referred to as "Producer" or "you"; Insurers Administrative Corporation will be referred to as "IAC", "us", or "we"; and the insuring carrier will be referred to as "the Company."

This guide does not guarantee that the underwriting practices referred to herein apply in all circumstances. The Company's actual underwriting practices in effect at the time an application is reviewed apply to the processing and underwriting of new business.

For additional information, please refer to:

- Plan Brochure
- Enrollment Application
- IAC Individual Insurance Plans Producer's Agreement
- Certificate of Coverage, Schedule of Benefits and Riders

Agent Appointment and Contracting

New Producers – Contact your IAC General Agent to determine licensing, appointment and contracting rules for the state(s) in which you do business prior to submitting any applications.

State License

Before you solicit business, you must have a current life/health insurance license for the state(s) in which you transact insurance.

Agent Appointment and Contracting Prior Approval

Producers must be appointed by the Company and have completed a Producer's Agreement with IAC. Some states allow Producers to submit the required appointment request with their initial case submission. Contact your IAC General Agent to verify whether the state(s) in which you do business allow this.

Please note: New Mexico, Pennsylvania and West Virginia require pre-appointment prior to the solicitation of business.

Producer Required Forms

Prior to or upon submission of your first case, please provide us with the following completed, signed and dated documents:

- Legible photocopy of your current state life/health insurance license(s), and, if applicable, legible photocopy of your current state life/health agency insurance license(s)
- IAC Requisition for Appointment form and Fidelity Security Life Insurance Company (FSL) Agent Data Sheet
- IAC Individual Plans Producer's Agreement
- State-required appointment forms, if applicable

Non-resident appointments

Producers must also provide a legible photocopy of their life/health license for the state(s) for which they desire non-resident appointment. The Company pays appointment fees for medical, life, and dental. The Producer is responsible for the appointment fee for Fidelity Security Life vision.

You will be notified when the insurance carrier appointment is complete and will be sent a copy of your executed Producer's Agreement. Until the insurance company completes your appointment, IAC may hold any commissions that are due.
You will receive notification of renewal of your appointment(s) and requests will be sent for updated copies of your insurance license.

Commission Information

Monthly commission statements can be accessed exclusively online at *www.iacusa.com* and are subject to the terms and conditions of the Producer's Agreement. For purposes of determining all first-year commissions and future years' Service Fees, all administration fees, premium rate increases whether or not due to medical and/or non-standard industry load(s), area rate increases, and conversions will not be included. Commissions will be paid based upon the lower of the first modal premium or the current premium.
"As earned" commissions are paid on the 15th of the month for premium that has been received and posted by the last day of the previous month, providing that the amount is greater than $25. For amounts less than $25, the balance will be forwarded to your next monthly statement. Direct deposit is available; you can obtain the required forms from your general agent.

If applicable, advance commissions are paid weekly on Fridays. The Friday advance includes any cases issued through the current week Wednesday for any amount greater than $25.00. For amounts less than $25, the balance will be forwarded to your next statement.

If any premium is refunded, then you will be required to repay any commissions that you have received on that refunded amount. Such refunds may be shown as adjustments on your commission statement.

To continue to receive commissions, the case must remain in-force with premiums paid and you must actively service the account.

Eligibility of Applicants

General Qualifications

An Application for Insurance must be completed and the applicant(s) must qualify for coverage according to the underwriting guidelines. For child(ren) only policies, a parent or legal guardian must sign the application and answer all medical questions for the child(ren) applying for coverage.

Issue Ages for Individual or Family Coverage

Adult applicants must be 18 - 64 years of age. Spouses must be legally recognized and under age 65. Dependent children must be unmarried and under age 19 (unless full-time students). Dependent children who are full-time students must be under age 25. Full-time, as used in this definition, means actively attending at least 12 hours of class a week or, if less, attending the minimum hours of class the school considers as full-time status.

Child(ren) Only Coverage

Child(ren) only applicants must be 2 months – 17 years of age. Newborn children cannot be added to a "child-only" plan. The youngest child to be covered must be listed as the applicant, and all other children listed under the dependent section of the application. Each child (including the applicant) is charged the per-child rate up to three children. Any additional children will be covered at no additional premium. When children covered under such policies attain age 18, they can be issued coverage under their own individual plan and charged an adult rate if they reside in a state where the coverage is available. Premium is based on the rates applicable to the state in which the child resides. Vision Benefits are not available for child(ren) only coverage.

On child(ren) only plans, the parent/guardian is always the applicant payer and must waive total coverage. On plans issued through the Communicating for America, Inc., the parent/guardian must be the owner of the Communicating for America membership.

Expectant Parenthood

No member of the family may be pregnant or an expectant parent (whether or not to be covered) at the time the application is being written. Current pregnancy is a medical condition that is *not* acceptable for applicants under the plans.

Disabled Applicants

Applicants who are currently disabled and receiving disability benefits are ineligible for coverage unless they are deemed federally eligible applicants under Health Insurance Portability and Accountability Act

(HIPAA) regulation. HIPAA applicants must submit a completed HIPAA Eligibility Questionnaire and a Certificate of Creditable Coverage (CCC) with the application.

Residence

The plan being applied for must be available for sale in the applicant's primary state of residence. Benefits and premiums are based on the rates applicable to the applicant's primary state of residence. Premiums are adjusted to reflect changes in the applicant's primary state of residence when they occur.

Foreign Nationals

American citizenship is not mandatory under this plan as long as the applicant is a legal resident of the U.S. A legal resident is defined as someone who is living in the United States on a full-time basis who has been issued permanent visa status, with only an occasional stay outside of the United States.

The following visa categories are acceptable to validate legal residency:

Primary Applicant	H-1A Nurses	H-1B Professionals	L-1 Intra-Company Transferees	TN Trade "NAFTA"	TC Canadians Only
Dependents	H-4	H-4	L-2	TD	TB
Note: The Dependent VISA category is tied to the Primary Applicant category directly above it. For example, if the primary applicant has a TN classification, his/her dependent(s) would have a TD classification.					

Canadian citizens are exempt from the visa and passport requirement of Immigration and Nationality Act. To enter the U.S., a Canadian citizen must be able to establish both identity and citizenship. Documents that may establish citizenship are birth certificate, citizenship certificate and passport.

Non-U.S. citizens must provide documentation that they are legal residents by providing a copy of their green card or visa (see chart above).

Overseas Travelers

Persons to be covered must not be planning or considering extended foreign travel, nor live outside the United States more than three months of the year. Dependents who are studying abroad are ineligible for coverage since they would be taking residence in a foreign country.

The plans exclude services received or supplies purchased outside the United States unless the charges are incurred while traveling on business or for pleasure, provided the procedure or treatment is approved for use in the United States.

Legal Custody

Dependents who do not meet the basic definition of eligible dependent but who are in the legal custody of the Insured may be considered for coverage subject to review of legal custody documents. Generally, temporary custody or powers of attorney are not considered sufficient legal documentation. There must be permanent custody documented by court order to qualify as an eligible dependent, except as otherwise mandated by state law.

Military Information

USERRA does not apply. Coverage will terminate for the entire certificate on the last day of the month in which the primary insured is called to active duty (assuming premium has been paid for that month). There is no reinstatement upon return from active duty. A new application needs to be submitted.

Common-law Relationships and Domestic Partners

Common-law relationships or domestic partners are not eligible for coverage, unless required by state mandate.

Medicare Eligible Individuals

Applicants currently eligible for Medicare coverage are not eligible. Individuals covered under this Plan prior to reaching Medicare eligible age may continue coverage after Medicare eligibility.

Ineligible Occupations

Applicants employed in any of the fields listed below are not eligible for coverage. Restrictions do not apply to child only coverage or Florida applicants. Florida & Michigan applicants are subject to a 45 percent additional premium assessment.

- Adult Entertainment Workers (Actors, Dancers, Escort Service Workers, etc.)
- Masseuse (Not licensed or not certified)
- Air Traffic Controllers
- Musicians (Not including symphony orchestra)
- Armed Forces Personnel
- Oil and Natural Gas Workers (Onshore or Off Shore)*
- Asbestos/ Toxic Chemical Workers*
- Professional Motor Vehicle Racers*
- Divers (Professional skin or scuba)
- Professional and Semi-Pro Athletes (Golf and Bowling Excepted)*
- Explorers
- Professional Rodeo Participants
- Explosives Workers
- Pyrotechnics
- Fire Fighters/Police Officers (Full Time)
- Roofers and Roofing Contractors*
- Fishermen/Crew not returning to port nightly*
- Structural Steel Workers*
- High Risk Aviation (Crop Dusters, Test Pilots, Stunt or Student Pilots)
- Underground Miners*
- Loggers or Logging Mill Workers*

**Special underwriting consideration will be given to business owners who do not participate in the normal duties of workers. This will occur on a case-by-case basis and be based on the size of the business and the likelihood the owner will perform the duties of his/ her employees in the event of a personnel shortage.*

Height and Weight Guidelines

The following Height and Weight Tables may be used as a guide to the premium load for overweight individuals provided there are no other medical impairments. Ask the applicant or adult family member his/her height and weight. Locate the height column under Male or Female table, and then read across until you find the applicant's weight. If height and weight falls within the stated values, apply the appropriate rate-up. Individuals whose weight exceeds the maximum for height would be declined coverage. We may require a paramedical examination to confirm an applicant's height and weight.

Examples:

A 6'0" male weighing 250 pounds would have a 20% rating.
A 6'0" male weighing 300 pounds would have a 70% rating.
A 4'10" female weighing 150 pounds would be accepted as standard.
A 5'0" female weighing 200 pounds would have a 70% rate-up.

If you have questions about heights/weights not listed on these charts, please contact your IAC General Agent for assistance.

Female Build Chart				
Height	**Normal**	**20% rate up**	**50% rate up**	**70% rate up**
4’10”	90-155	156-170	171-182	183-196
4’ 11”	90-160	161-175	176-187	188-199
5’ 0”	94-165	166-180	181-192	193-204
5’ 1”	96-170	171-185	186-198	199-209
5’ 2”	97-175	176-190	191-203	204-214
5’ 3”	99-180	181-195	196-208	209-219
5’ 4”	102-185	186-200	201-214	215-226
5’ 5”	105-190	191-205	206-219	220-231
5’ 6”	108-195	196-210	211-224	225-236
5’ 7”	111-200	201-215	216-230	231-241
5’ 8”	115-205	206-220	221-235	236-246
5’ 9”	118-212	213-228	229-242	243-256
5’ 10”	122-219	220-235	236-249	250-263
5’ 11”	125-225	226-242	243-258	259-271
6’ 0”	129-230	231-250	251-267	268-281
6’ 1”	132-238	239-257	258-275	276-289
6’ 2”	135-245	246-265	266-280	281-296
6’ 3”	138-250	251-270	271-285	286-301
6’ 4”	142-255	256-276	277-295	296-306
6’ 5”	146-260	261-285	286-300	301-311
6’ 6”	150-265	266-290	291-305	306-316

Male Build Chart				
Height	**Normal**	**20% rate up**	**50% rate up**	**70% rate up**
4’10”	100-174	175-191	192-208	209-226
4’ 11”	102-178	179-196	197-214	215-232
5’ 0”	103-181	182-199	200-217	218-235
5’ 1”	105-183	184-201	202-219	220-237
5’ 2”	106-186	187-205	206-224	225-243
5’ 3”	109-190	191-209	210-228	229-247
5’ 4”	112-196	197-216	217-236	237-256
5’ 5”	115-202	203-222	223-242	243-262
5’ 6”	118-207	208-228	229-249	250-270
5’ 7”	122-213	214-234	235-255	256-276
5’ 8”	126-220	221-242	243-264	265-286
5’ 9”	130-227	228-250	251-274	275-296
5’ 10”	134-230	231-253	254-276	277-299
5’ 11”	138-236	237-260	261-284	285-308
6’ 0”	142-240	241-264	265-288	289-312
6’ 1”	147-248	249-273	274-298	299-323
6’ 2”	153-253	254-278	279-303	304-328
6’ 3”	158-261	262-287	288-313	314-339
6’ 4”	163-269	270-306	307-333	334-360
6’ 5”	169-275	276-313	314-340	341-368
6’ 6”	174-282	283-320	321-348	349-377
6’ 7”	178-290	291-330	331-359	360-389
6’ 8”	182-296	297-337	338-367	368-398
6’ 9”	186-303	304-345	346-375	376-407
6’ 10”	190-308	309-351	352-382	383-415
6’ 11”	194-316	317-360	361-392	393-426
7’ 0”	198-322	323-367	368-400	401-435

Juvenile Applicants 15 and Under Build Chart								
Ages 0 - 2			Ages 3 - 9			Ages 10 - 14		
Height (In.)	**Min.**	**Max.**	**Height (In.)**	**Min.**	**Max.**	**Height (In.)**	**Min.**	**Max.**
24	8	23	30	18	40	48	44	92
26	10	26	34	22	44	52	54	108
28	13	31	38	26	54	56	63	126
30	15	36	42	32	64	60	74	144
32	18	40	46	38	78	64	87	166
34	21	42	50	46	94	68	100	186
36	23	45	54	56	111	72	113	206
38	26	48	58	66	128	76	126	228
40	29	52						

Application Process

Business may be submitted either electronically or using a paper application.

Paper Application

- The applicant (or parent/legal guardian in the case of a child-only application) should complete the application.
- The application must be completed in either black or blue ink, printing legibly. Information cannot be changed with correction fluid, blacked out or altered in any manner. If an error is made, the applicant should cross through the word or line with a single stroke, then initial and date the correction.
- The applicant's street address must be included. A post office box may *not* be used as the applicant's residence address, but may be listed as the billing address. The billing address must be located in the same state as the residence address.
- All "yes" answers to medical questions must include required details. Insufficient information will cause a delay in underwriting and can result in denial of coverage.
- The applicant (and spouse, if applying) must sign and date the completed application under "Evidence of insurability," "Health History and Agreement" and signature sections. Original signatures are required on and spouses may not sign for each other.
- The Producing Agent Information must be fully completed, signed and dated. Refer to the application for a checklist of required forms and items to be submitted with the application. For split commissions, both agents must sign the "Producer/General Agent Information" section and indicate the spilt percentage.

On-Line Application

For instructions on accessing the online quoting and enrollment tool, please contract your General Agent or IAC Marketing Technology at 800-446-1223. The applicant (or parent/legal guardian in the case of a child-only application) should assist the producer in the completion of the on-line application.

Payment Information

The applicant's personal check or money order for the first month's premium, including the application fee, administration fee, managed care fee, and association fee (if applicable) must accompany the application. Business checks from an employer for an employee's premium, post-dated checks, checking deposit slips and agency checks are not acceptable. Oklahoma, Tennessee, Virginia and Wisconsin business checks are accepted with Sole Entity form. In Colorado, business checks are accepted only if the applicant is applying for coverage as a "business group of one." Applications received without premiums will be pended without medical decision until premium is received. Applications submitted electronically through PHP Online, when paying by bank draft or credit card, will only be charged the application fee.

Billing Modes and Options

A variety of billing modes and options are available.

	Credit Card	Bank Draft	Direct Bill	List Bill
Monthly	X	X	X	X
Quarterly			X	
Semi-Annual			X	

Credit Card: Monthly premiums may be paid via MasterCard or Visa only. The sum of the monthly premium, *including* applicable fees (see Premium and Related Fee Information above), should be indicated, along with the credit card number, expiration date, and credit card billing address. *No initial deposit check is required with this billing method.* Credit card payment is available on a monthly mode only. Credit card premiums and fees will automatically be charged on the 1st or the 15th depending on your elected effective date, of each month according to the mode of payment selected. For the initial month only, the one-time, non-refundable application fee will be included in the premium amount. If an application is declined, withdrawn or closed-out, only the one-time, non-refundable application fee will be assessed.

Automatic Bank Draft: A voided original blank check (not a photocopy) or savings deposit slip must be attached to this form, along with a completed, endorsed check in the sum of the application fee, payable to "Insurers Administrative Corporation (IAC)" or ensure the Monthly Automatic Payment Plan section is completed to include the bank routing and account information. Incomplete information, will require the submission of a voided blank check. Bank drafts will be drawn on the 1st or 15th day of each month depending upon bill cycle.

If a voided blank check is submitted with a paper application, the application fee will be drafted immediately and balance will be drafted at time of issue.

Direct Bill: A personal check or money order in the sum of the full modal amount of the premium due, including applicable fees (see Premium Information and Related Fees Information above) should be submitted with the application. **Direct Bill is not available when applying on-line.**

List Billing/Payroll Deduction: This is offered as a convenience for collecting an individual's premium from an employer or other payor and is not intended to be used as an employer-sponsored plan. The employer may not pay any part of the insured's premium. All applicants requesting participation in a list billing are underwritten on an individual basis and should be advised as such.

List billing is currently available in all states **except:**

- Colorado
- Kansas
- Michigan
- North Carolina
- South Dakota
- Tennessee
- Virginia
- Wisconsin

This listing is subject to change. List billing is available in Florida only when the employer has not had a group health benefit plan in place within the prior six months, merely collects the premium and does not contribute toward the premium. If the FL employer currently has a group health benefit plan in place **only** part-time, temporary or substitute employees who are **not** eligible under the employer's group plan can apply for this insurance and request list bill. In Florida, the coverage can only be marketed directly to the individual employee; not through the employer and with no employer involvement. **If you are submitting list bill business through our online quoting and enrollment tool, please submit a paper List Bill Election Form to IAC Underwriting to ensure your cases are accurately established and administered.**

Effective Dates

The applicant may request a plan effective date of either the 1st or 15th of the month.

Insurers Administrative Corporation must receive the application for insurance *before* the requested effective date. If an application is received *after* the requested effective date, then coverage (if approved) will be made effective the next available date.

If the applicant is **replacing coverage**, it may be beneficial to elect an effective date of the 1st of the month following approval and keep his/her current coverage in force until notice of approval is received.

If a specific effective date is requested, that date will be honored unless we cannot approve the application within 30 days of the requested effective date (or 60 days, if the applicant is not replacing coverage). A requested effective date cannot be changed once the coverage is issued. After 30 days, the effective date will be the 1st or the 15th of the month following approval. After 60 days, a new application will be required.

Medical Underwriting Guidelines

We reserve the right to reject any application that, in our opinion, does not conform to sound underwriting principles. Telephone interview, paramedical exam, or Attending Physician Statement (APS) may be requested.

If a health condition prevents coverage from being issued as applied for, coverage may be considered with a medical impairment rider that excludes coverage for a particular health condition, or coverage may be considered at a higher premium or deductible, depending upon the nature of the medical condition. The applicant's coverage will be issued contingent upon the his/ her acceptance of the modified offer by signing, dating and returning the required forms to IAC within the allotted timeframe

Underwriting Requirements

Medical records are required:

- For all applicants ages 60 and over replacing prior health insurance coverage
- 70% ratable build
- For all applicants ages 50 and over **not** replacing prior health insurance coverage
- For all applicants ages 50 and over with two or more coronary risk factors (high blood pressure, elevated cholesterol, overweight and tobacco use)
- At the discretion of the Underwriter when the medical history presented on the application indicates that records are necessary to better define the potential risk

Telephone Health Questionnaires are required:

- For all applicants ages 50 and over
- For all children ages 2 and younger
- At the discretion of the Underwriter when the medical history presented on the application indicates that records are necessary to better define the potential risk

Para-medical Examinations are required:

- At age 60 and over for all applicants replacing prior health insurance coverage and have not seen a doctor within the past two years
- At age 50 and over for all applicants not replacing prior health insurance coverage and have not seen a doctor within the past two years

Prescription Drug Screen is required:

- on any applicant applying as a Preferred Underwriting Risk
- All primary applicants 18 years and older
- All spouses 18 years and older

MIB

- All primary applicants 18 years and older
- All spouses 18 years and older.

Foreign Nationals are required:

- to have established care in the United States before an application can be accepted

Long-Term Tobacco Use:

- An additional premium load of 15% is assessed for individuals who use tobacco ages 45 and over and who are determined to smoke over 1 pack of cigarettes per day

Preferred Underwriting Risks

Coverage may be applied for at a preferred rate for preferred risks. Applicants need to complete and submit a "Preferred Rating Questionnaire" with the Application for Insurance to be considered for a preferred rate.

Pre-Existing Conditions

The policy defines pre-existing conditions as "any condition (whether physical or mental) , regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was received within the 12 month period ending on the Effective Date of the Covered Persons coverage".

No benefits will be payable for expenses incurred in connection with pre-existing conditions as defined above until coverage has been: a) in effect for a 12-month period ending while the individual is covered for these medical expense benefits and during which he/she incurred no medical care or treatment expenses in connection with such bodily injury or sickness; b) a 24-month period during which the individual has been continuously covered for these medical expenses under the plan; or c) medical conditions fully disclosed.

Pre-existing condition definitions and time limits may vary by state. Contact your IAC General Agent for state-specific information.

Covered health conditions that are fully disclosed in writing on the application are covered from the effective date of coverage under the policy unless the condition is specifically excluded by endorsement or health condition rider attached to the certificate of coverage.

Attending Physician's Statement

Coverage may be considered for applicants who have various medical conditions, but an Attending Physician's Statement (APS) may be required. If an APS is needed, IAC will make the necessary arrangements to order and pay for the medical records (up to a maximum amount).

Impairment Riders

Coverage may be available for applicants with certain medical conditions if they accept an Exclusion Endorsement for a specified condition.. Exclusion Endorsements are permanent and do not expire. If an applicant is offered a Specified Condition Waiver Rider, he/she has 15 days from the date the amendment is mailed to sign and return it to IAC, or the case will be closed out.

Consideration to remove the rider may be given after coverage has been in force for at least 12 months. The insured must request in writing that the rider be removed and provide information concerning any medical care or treatment relating to the excluded condition. Following are examples of medical conditions likely to require impairment riders:

Sample Conditions Requiring Impairment Riders

Allergies
Arthritis, Osteoarthritis
Asthma
Back or neck disorder
Bells Palsy
Carpal Tunnel Syndrome
Cataracts
Disc surgery, within 5 years
Ear infections and disorders, recurrent
Endometriosis (unoperated)
Gall stones (unoperated)
Glaucoma
Hernia, present
Joint replacement/knee disorders
Menstrual disorders
Migraine headaches
Phlebitis
Ulcer
Ulcerative Colitis, no symptoms for 5 years
Varicose veins

Unacceptable Health Conditions

Each person to be covered must qualify medically as determined in accordance with the underwriting guidelines. Persons with serious existing health conditions may not qualify for coverage. Individuals who are contemplating surgery or hospitalization, have undiagnosed ailments or symptoms indicating a potentially serious condition, or are disabled, are not eligible for coverage.

Some impairments can be considered if there has been remission for at least 10 years. Refer to the following table for a listing of unacceptable health conditions that would result in a declination of coverage. Please note that not every unacceptable health condition may be listed.

Unacceptable Health Conditions

Addison's Disease
AIDS/ARC/HIV & other immune disorders
Alcoholism, alcohol abuse
ALS (Lou Gehrig's Disease)
Alzheimer's Disease
Amputation – disease related
Aneurysm
Angina Pectoris
Anorexia Nervosa
Anxiety disorders (selected)
Aplastic Anemia
Arteriosclerosis
Atherosclerosis
Arthritis – rheumatoid
Autism
Bechet's Syndrome
Bipolar disorder
Boeck's Sarcoid
Bone marrow transplant
Brain tumor
Buerger's Disease
Bulimia
Bypass surgery
Cancer
Cardiac pacemaker
Cardiomyopathy
Cerebral Palsy
Cirrhosis of the liver
Combined System Disease
Congestive heart failure
Coronary Artery Disease
Coronary bypass surgery
Crohn's Disease
Cystic Fibrosis
Dementia
Dermatomyositis
Diabetes (except gestational)
Down's Syndrome
Drug abuse/addiction
Emphysema
Endocarditis
Epilepsy (Grand Mal)
Fetal Alcohol Syndrome
Gangrene
Gastrionoma
Gaucher's Disease
Heart attack/disease
Hemophilia
Hepatitis C
Hodgkin's Disease
Huntington's Chorea
Hydrocephalus
Juvenile arthritis
Kidney transplant
Leukemia
Liver transplant
Lupus Erythemotosus
Lymphoma
Malignant melanoma
Marfan's Syndrome
Mental retardation
Multiple Sclerosis
Muscular Dystrophy
Myasthenia Gravis
Myelofibrosis
Myocardial Infarction
Nephrosclerosis
Organ transplant
Organic Brain Syndrome
Pacemaker
Paralysis
Parkinson's Disease
Pemphigus
Pericholangitis
Pneumoconiosis
Poliomyelitis
Polycythemia
Polymyositis
Porphuria
Pregnancy/Infertility*
Primary Pulmonary Hypertension
Prosthetic heart valve
Psychotic disorders
Polycystic Kidney Disease
Pulmonary embolism
Pulmonic steriosis
Renal disease (ESRD)
Rheumatoid arthritis
Scleroderma
Sickle Cell Anemia
Simmond's Disease
Stroke
Suicide attempt
Syphilis
Ventricular fibrillation
Whipple's Disease

**Pregnancy: No family member (whether or not to be covered) may be pregnant or an expectant parent at the time of application.*

Life Insurance

Up to $100,000 in optional life insurance is available to the primary insured. Life insurance is not available in Florida, Georgia, Kansas or Texas. For child(ren) only policies, if optional life insurance is elected, the youngest child is only eligible to have $10,000 life insurance.

Withdrawals

In order to withdraw an application, either the applicant or Producer must submit a written request to discontinue the underwriting process. The submitted premium less the non-refundable application fee will be returned to the applicant. If the applicant reapplies at a later date, a new application and non-refundable application fee is required.

Rescission of Coverage

False or misleading information on the application may be the basis for rescission of coverage. Rescission voids the coverage back to the effective date. Be sure that the applicant completes the application accurately, including *all* answers to medical questions and height and weight information.

Delivery of the Certificate

Producers may indicate on the Application for Insurance if the fulfillment kit is to be mailed to them or the insured. Producers must deliver the fulfillment kit to the insured within 30 days of the date it was mailed.

Role of the General Agent

All paper applications and additional information should be submitted directly to your IAC General Agent. They will review and submit the application to IAC, and follow the application through the underwriting process. If you have any questions about application status or other matters, please contact your IAC General Agent.

Guidelines for Producers

Always provide the applicant with full information relative to the plan(s) you are presenting. Describe the benefits and requirements, including pre-certification, pre-existing condition limitations and exclusions, managed care, satisfaction of deductibles, coinsurance levels, copayments, and other limitations and exclusions. Refer to the plan brochure, Application for Insurance, policy documents and this Producer Guide. If you have questions that are not answered by these materials, contact your IAC General Agent.

You are not authorized to promise a specific effective date or bind coverage. The applicant should never cancel any existing coverage until you are notified by of acceptance by IAC.

Inforce Administration Changes

When an applicant wants to add a family member, a fully completed, currently dated application is needed. The family discount is only available at the original date of issue and will not be applied after the policy is issued. However, the family discount will be removed if a full family is no longer insured. Plan change requests must be submitted in writing to IAC's In-force Administration Department. If approved, the request becomes effective on the 1st or the 15th, depending on the elected effective date of the month following receipt of the request. All requests to add on family members or make plan changes are subject to the Company's guidelines in effect at the time the request is made.

Please note: Certain in-force actions may result in changes in premium. These include but are not limited to: applicant change of address or location; age band changes; benefit plan changes; and managed care fees.

Type of Change	Requirements	UW Required?	IAC Action
Name	Written request and legal documentation	No	Letter confirming the change, new Validation of Coverage /Schedule of Benefits and ID cards will be sent to the insured.
Address	Phone or written request	No	Letter confirming the change sent to the insured.
Newborn Baby Addition	Written request within 31 days ------------------------ Completed application if after 31 days	No ------------- Yes	Letter confirming the addition, new Validation of Coverage /Schedule of Benefits and ID cards will be sent to the insured.
Add a Family Member (other than newborn)	Completed application	Yes	Letter confirming the addition, new Validation of Coverage /Schedule of Benefits and ID card sent to the insured.
Remove a Family Member	Written request from the primary insured	No	Letter confirming the change, new Validation of Coverage /Schedule of Benefits and ID card sent to the insured.
Mode of Payment – from direct bill to monthly bank draft or credit card	Written request, Monthly Automatic Payment Plan form and voided check (if applicable)	No	Letter to notify of change and amount to be drafted.
Mode of Payment – bank draft to direct bill	Phone or written request	No	Revised billing mailed.
Lower Deductible	Written request from the primary insured with new completed medical section of the application	Yes	If approved, letter confirming the change, new Validation of Coverage /Schedule of Benefits and ID card (if affected by the change). If declined, letter is sent notifying insured of decision.
Increase Deductible	Written request from the primary insured	No	Letter confirming the change, new Validation of Coverage /Schedule of Benefits and ID card (if affected by the change).

Type of Change	Requirements	UW Required?	IAC Action
Add Wellness or Accident Rider	Written request from the primary insured	No	Letter confirming the change and new Validation of Coverage /Schedule of Benefits sent to the insured.
Add or Modify Prescription Drug	Written request from the primary insured with new	Yes	If approved, letter confirming the change and new Validation

Card Rider Benefit	completed medical section of the application		of Coverage /Schedule of Benefits. If declined, letter is sent notifying insured of decision.
Remove a Benefit Rider	Written request from the primary insured	No	Letter confirming the change and Validation of Coverage/Schedule of Benefits sent to the insured.
PPO Network Change	Written request from the primary insured	No	Letter confirming the change and new ID card sent to the insured.
Request for Removal of an Exclusion Endorsement or Rating	After 12 months of coverage, written request from the primary insured and all medical records regarding the condition at the insured's expense	Yes	If approved, letter confirming the change is sent to the insured. If declined, letter is sent notifying insured of decision.
Continuation for Dependent	Written request from the Continuing Dependent if age 19 or over because no they are longer eligible. Also, written request from the current primary member removing the dependent from coverage.	No	Letter confirming the continuation, new Validation of Coverage /Schedule of Benefits and ID card send to dependent and the current primary insured.
Plan change – lesser benefits	Written request from the primary insured.	No	Letter confirming the change and new Validation of Coverage /Schedule of Benefits sent to the insured.
Plan change - better benefits	Written request from the primary insured with new completed medical section of the application.	Yes	If approved, Letter confirming the change and new Validation of Coverage /Schedule of Benefits sent to the insured. If declined, letter is sent notifying insured of decision.
Termination of Coverage	Written Request from the Primary Insured Note: Terminations are made effective on the 1st or 15th of the month (depending on the premium due date) following receipt of the request or the last fully paid month.	No	Letter to confirm the termination and Certificate of Creditable Coverage sent to insured.

Questions and Answers

Who is the Administrator of the Plan?
Insurers Administrative Corporation (IAC), a member of the IHC Group, is a leading administration and marketing organization in the fully insured, self-funded and international health insurance markets. Established in 1978, IAC specializes in small group major medical (2 - 50 lives), individual and family major medical, short-term medical, dental and other insurance products.

Who is the Insurance Company for Health and Life Insurance?
Standard Security Life Insurance Company of New York is the insurer for health and life insurance benefits. A member of the IHC Group, Standard Security Life Insurance Company of New York, is rated A- (Excellent) by A.M. Best Company, a widely recognized rating agency that rates the relative financial strength of insurance companies and their ability to meet policyholder obligations.

The IHC Group is an insurance organization comprised of Independence Holding Company (NYSE: IHC), its operating subsidiaries and affiliates. With more than $1.3 billion in assets, the IHC Group serves more than one million customers through its operating companies, which include three A- (Excellent) A.M. Best-rated insurance carriers, third-party administrators, managing general underwriters and marketing organizations. The IHC Group has been providing life, health and stop-loss insurance solutions for over 25 years.

Who is the Insurance Company for the Vision Plan?
Fidelity Security Life Insurance Company of Kansas City, Mo. underwrites the vision coverage. Fidelity Security Life Insurance Company has been rated A- (Excellent), based on an analysis of financial position and operating performance, by A.M. Best Company, an independent analyst of the insurance industry.

Who is Communicating for America?
Communicating for America, Inc. (CA) endorses the IAC Personal Health Plans and is a national non-profit association founded in 1972. Originally founded as an advocate for the self-employed and rural members, CA has evolved into one of the largest and most respected associations in the country with members in communities of all sizes. Along with a legislative voice on important issues in Washington, D.C., CA provides high quality, valuable member benefits. CA, Inc. is not compensated by Standard Security Life Insurance Company of New York for its endorsement. Communicating of America association membership is not required or available in Colorado, Georgia, Kansas, Montana and South Dakota.

Contact Information

Who do I contact with questions?
Our underwriting address is:
IAC Underwriting
1173 W. Main St., Ste E.
Whitewater, WI 53190

See chart below for applicable phone numbers.

Administration/Billing	***Sales***	***Underwriting***
800-518-4510	800-446-1223	866-472-6555
602-906-6310	602-395-7095	602-674-9015 New Business Fax
602-906-4745 Fax	602-906-4714 Fax	866-570-5234 General Fax