

No one plans to have an unexpected illness or accident happen to them.

But let's face it — the unexpected *does* happen. That's why going without health insurance, even for a short time, puts you or your family at serious financial risk. Consider this — a basic knee injury could cost up to \$12,000\* of your hard-earned money.

**Don't take the chance!** Short Term Medical from Fortis Health provides affordable, health coverage that protects you or your family — *for only dollars a day.*

Short Term Medical is a temporary health insurance plan (30-185 days) designed for people who are between permanent health plans. Whether you are:

- Between jobs,
- Waiting for employer group coverage,
- A recent college graduate,
- A temporary or seasonal employee,
- A dependent falling off your parent's plan,
- A laid-off, striking or terminating employee,

Short Term Medical can provide you with the peace of mind you deserve.

\*Based on 2001 Fortis Health Short Term Medical claims.

## Here's How The Plan Works

You choose the plan that best meets your needs and budget! Simply select from your choice of deductibles, rate of payment options and length of coverage. Since this plan is not an HMO or PPO, you choose your own doctors and hospitals.

- **Deductible choices:**  
\$250, \$500, \$1000 or \$2500\*
- **Rate of payment options:**  
\$0/20 to \$5000 or \$0/50 to \$5000\*
- **Length of coverage options:** 30-185 days\*

\*May vary by state. The \$0/50 rate of payment option is not available in OK.

Benefits are paid as follows:

FIRST	THEN	THEREAFTER
You pay the deductible for each covered person.	Once the deductible is satisfied, Fortis Health pays either 80% or 50% of the next \$5,000 of covered expenses, depending on the rate of payment you selected. You pay the remaining 20% or 50%.	Fortis Health pays 100% of remaining covered expenses up to the plan maximum of \$2 million for each covered person.

## Who Is Eligible For This Plan?

- Healthy individuals between the ages of 15 days and age 64 and 11 months, who have a temporary insurance need.
- Dependent children through age 20 (age 24 if full-time student) may be covered as dependents on their parent's plan.
- Foreign residents living in the U.S. for at least one year with proof of an Alien Registration Receipt Card, Green Card, Visa, or other appropriate documentation.

## Plan Highlights

- \$2 million coverage maximum per policy period
- Freedom to choose your own doctors and hospitals
- Prescription drug coverage
- Excellent in-hospital and outpatient benefits
- Semi private room and board
- Intensive care
- Lab and x-ray

- Ambulance service
- Managed care/pre-authorization procedure
- Maximum family deductible equal to three times your individual deductible amount
- Maximum family premium capped at three dependents regardless of the number of dependent children
- Extension of Benefits\* — up to 12 months if totally disabled
- Extension of Benefits Plus\* — 60 day/\$1,000 benefit for non-disabling conditions
- No association fees

\*Coverage may be extended beyond your policy period. See your policy for details.

## Plan Exclusions

Fortis Health's Short Term Medical plan is a temporary plan of insurance and does not cover: preexisting conditions\*; intentionally self-inflicted injury; free services; services covered by Worker's Compensation or Occupational Disease laws; dental treatment; eyeglasses, contact lenses, hearing aids, eye exams; routine physical exams and immunizations; normal pregnancy or childbirth, routine well child care; sterilization, treatment for infertility; genetic testing or counseling; weight reduction or weight control programs and related surgery; medication to simulate growth; mental disorders, mental illness or substance abuse except as may be provided by an Amendment Rider; treatment for learning disorders or disabilities; removal of tonsils or adenoids; custodial care; repairs or replacement to prosthetic devices; cosmetic treatment or reconstructive or plastic surgery that is primarily a cosmetic procedure; expenses incurred outside the United States; its possessions, territories or Canada; or experimental investigative treatment. Other exclusions as well as other covered services are listed in detail in the policy or certificate you will receive when you purchase Short Term Medical.

\*Preexisting Condition: An illness or injury for which the covered person received medical treatment or advice from a physician within the 5-year period (may vary by state) immediately preceding the covered person's effective date; or that produced signs or symptoms within the 5-year period (may vary by state) immediately preceding the covered person's effective date.

## Choose From Two Convenient Payment Options

Fortis Health makes paying for your policy easy by offering two convenient payment options.

The **single payment option** is ideal if you know the exact number of days coverage is needed. The minimum number of days you may apply for is 30 and the maximum is 185.

The **monthly payment option** is ideal if you are unsure how long you need coverage. This "pay as you go" option gives you the flexibility to continue coverage for as long as it's needed (up to 185 days) or simply stop payments and discontinue the plan once your temporary need ends.

- If you pay your initial premium by **Mastercard or Visa** each additional 30 days of coverage will be automatically charged to your credit card for up to 185 days of coverage.
- If you pay your initial premium by **check or Discover card** shortly after you receive your contract, Fortis Insurance Company will send you payment coupons. Each coupon is for an additional 30 days of coverage.

## Money Back Guarantee!

If you are not 100 percent satisfied with the plan, you may return the contract and identification cards within 10 days of delivery for a full refund. No questions asked!

## When Does Your Coverage Begin?

**Your effective date of coverage will begin on the later of:** 1) 12:01 a.m. the day after your requested policy date; or 2) 12:01 a.m. the day after the postmark date affixed by the U.S. Post Office\*, provided the following conditions are met:

- Your application and the full premium payment are received by your agent or Fortis Health;
- Your answers on the application are complete and meet the requirements for acceptance.

\* If the envelope containing your application is not postmarked by the U.S. Post Office, or if the postmark is not legible, the policy date will be the later of: a) your requested date; or b) two days prior to the date the application is received by mail by your agent or Fortis Health.

## Authorization Is Required For Certain Services.

Fortis Health uses an authorization service which ensures that you and your family receive the most appropriate and cost effective care available. The authorization process must be followed in its entirety to receive maximum benefits. This process is explained in detail for you in the contract. **Benefits for unauthorized services of otherwise covered expenses will be reduced.** No benefits will be paid for a transplant if the procedure was not authorized prior to the beginning of the donor search and selection.

## Can A Second Plan Be Purchased?

Fortis Health's Short Term Medical plan is **non-renewable**. However, if your temporary need continues beyond your policy period, you may apply for one additional plan under the following circumstances:

- No claims were incurred under a previous Short Term Medical plan;
- There has been no significant change in health;
- The total days of coverage for all plans does not exceed 365 days.

To obtain a second plan, you must complete a new application. If a second application is approved, a new plan will be issued. Please Note: There is no continuous coverage between the original and second plan. Any condition or symptom which may have occurred under the first plan will be treated as a preexisting condition under the second plan and therefore will not be covered.

## Apply Now!

Applying for Short Term Medical is as easy as 1-2-3!

1. Complete all information, sign and date the application.
2. Calculate the premium for the coverage of your choice. Refer to the Premium Calculation Instructions Section.
3. Detach the application, insert it in the envelope with your payment and mail it to your agent.

If you have any questions, please contact the agent listed on the brochure or call Fortis Health at 1-800-800-5453.

### Premium Calculation Instructions

1. Choose a payment option — single or monthly. Find the rate charts on the next panel. Use the chart that matches your payment choice. List and add each applicant's rate for your selected deductible.

M \$ \_\_\_\_\_ A  
 F \$ \_\_\_\_\_ B  
 Child \$ \_\_\_\_\_ C  
 Total \$ \_\_\_\_\_ D

2. Enter the number of days of coverage needed on Line E. For single pay, the minimum number of days is 30, the maximum is 185. For Monthly Payment Option enter 35 days to calculate the first premium and 30 days to calculate future premium due. Multiply Line D by E. Enter the result on Line F.

X \_\_\_\_\_ E  
 Days of Coverage  
 \_\_\_\_\_ F

3. Refer to the ZIP Code Factor Table. Find the first 3 digits of your ZIP code, and enter the factor on Line G. Multiply Line F by G. Enter total on Premium Due Line. Enter this amount on application. (Rates shown are based on the 80/20 rate of payment. To obtain the 20% premium savings for the 50/50 rate of payment, multiply the premium due by .80.) (N/A in OK.) To ensure prompt processing of your application, double check your calculations.

X \_\_\_\_\_ G  
 ZIP Code Factor  
 \_\_\_\_\_ PREMIUM DUE

4. Make your check or money order payable to Fortis Insurance Company. Mastercard, VISA and Discover payments are accepted.

**About This Brochure:** This brochure provides a brief description of the important features of this plan. This is not the insurance contract. The actual plan sets forth in detail the rights and obligations of both you and your insurance company. State mandated benefits, if applicable, are incorporated through a rider attached to your plan.

Short Term Medical is issued and underwritten by Fortis Insurance Company, Milwaukee, WI.

### Single Payment

Age	\$250 Ded.		\$500 Ded.		\$1,000 Ded.		\$2,500 Ded.	
	M	F	M	F	M	F	M	F
0-24	1.90	2.20	1.60	1.80	1.20	1.30	1.00	1.10
25-29	2.10	2.60	1.60	1.90	1.20	1.40	1.00	1.10
30-34	2.20	3.00	1.80	2.40	1.20	1.70	1.00	1.40
35-39	2.80	3.50	2.20	2.80	1.50	2.00	1.20	1.60
40-44	3.20	3.60	2.70	3.10	1.90	2.30	1.60	1.80
45-49	3.90	4.40	3.10	3.60	2.50	2.80	1.90	2.20
50-54	5.20	5.20	4.20	4.20	3.30	3.10	2.60	2.50
55-59	7.00	6.50	5.90	5.30	4.40	4.00	3.50	3.20
60-64	10.40	7.70	8.30	6.10	6.30	4.60	5.00	3.60
1 Child	1.30		1.00		0.80		0.40	
2 Children	2.50		1.90		1.50		0.80	
3+ Children	3.50		2.70		2.20		1.10	

### Monthly Payment

Age	\$250 Ded.		\$500 Ded.		\$1,000 Ded.		\$2,500 Ded.	
	M	F	M	F	M	F	M	F
0-24	2.28	2.64	1.92	2.16	1.44	1.56	1.20	1.32
25-29	2.52	3.12	1.92	2.28	1.44	1.68	1.20	1.32
30-34	2.64	3.60	2.16	2.88	1.44	2.04	1.20	1.68
35-39	3.36	4.20	2.64	3.36	1.80	2.40	1.44	1.92
40-44	3.84	4.56	3.24	3.72	2.28	2.76	1.92	2.16
45-49	4.68	5.28	3.72	4.32	3.00	3.36	2.28	2.64
50-54	6.24	6.24	5.04	5.04	3.96	3.72	3.12	3.00
55-59	8.40	7.80	7.08	6.36	5.28	4.80	4.20	3.84
60-64	12.48	9.24	9.96	7.32	7.56	5.52	6.00	4.32
1 Child	1.56		1.20		0.96		0.48	
2 Children	3.00		2.28		1.80		0.96	
3+ Children	4.20		3.24		2.64		1.32	

M = Male F = Female  
 Single Pay minimum 30 days.

Rates shown are daily.  
 Monthly Pay minimum 35 days.

### ZIP Code Factor Table

Find the first three digits of your resident address ZIP code in the STATE/ZIP CODE column. Locate the multiplication factor in the FACTOR column. If your specific ZIP code is not shown, use the others factor. ZIP codes shown together are inclusive. (Example: 773-777 includes 773, 774, 776, 778 and 777.)

STATE / FACTOR			
<b>AL</b>	<b>IN</b>	<b>MO</b>	<b>PA</b>
350-352..... 1.00	462-463..... .70	639-641..... .80	151, 152..... 1.0
Others..... .90	485-486..... .70	630-633..... .90	189, 193..... 1.0
<b>AZ</b>	464..... 1.00	Others..... .70	194..... 1.2
850-853..... .80	Others..... .60	<b>NE</b>	190, 191..... 1.3
Others..... .70	<b>IA</b>	661..... .70	Others..... .90
<b>AR</b>	Others..... .60	Others..... .60	<b>TN</b>
716-723..... .70	<b>KS</b>	<b>NH</b>	370-372..... .60
728..... .70	660..... .80	Others..... .80	381..... .80
Others..... .60	661-663..... .90	<b>ND</b>	Others..... .70
<b>CT</b>	Others..... .70	Others..... .60	<b>VA</b>
068-069..... .90	<b>KY</b>	<b>OH</b>	201, 220..... .90
Others..... .80	402..... 1.1	442-445..... .80	221..... 1.0
<b>DE</b>	Others..... .90	436, 440..... .90	222, 223..... 1.10
Others..... .80	<b>LA</b>	441..... 1.00	Others..... .70
<b>DC</b>	700, 701..... 1.00	Others..... .70	<b>WV</b>
Others..... 1.20	704..... 1.00	<b>OK</b>	250-253..... .80
<b>ID</b>	Others..... .90	730, 741..... .80	255-257..... .80
Others..... .70	<b>MS</b>	731..... .90	Others..... .70
	Others..... .80	Others..... .70	<b>WY</b>
			Others..... .70

Optional riders may be available in your state. For more information, call 1-800-800-5453. If your state is not listed, contact your agent for a separate state specific application.

This plan is unavailable to residents of Alaska, Hawaii, Massachusetts, New Jersey, New York, Rhode Island and Vermont.

**POLICY DATE**

Month	Day	Year
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**SHORT TERM MEDICAL POLICY  
APPLICATION AND SCHEDULE**  
**THIS POLICY IS NOT RENEWABLE**
**POLICY NUMBER**
**ST**

INSURED'S NAME (Print Last, First, Middle)		SEX	BIRTHDATE (M-D-Y)	SOCIAL SECURITY NUMBER	
		M		--	
STREET ADDRESS			CITY, STATE, ZIP CODE		
SPOUSE'S NAME (If to be insured)		SEX	BIRTHDATE (M-D-Y)	SOCIAL SECURITY NUMBER	
				--	
CHILDREN (First Name) (If to be insured)	BIRTHDATE	FIRST NAME	BIRTHDATE	FIRST NAME	BIRTHDATE
1.		3.		5.	
2.		4.		6.	

**Answer the following questions completely and accurately.**
**Yes No**

- Do you or any person to be insured have any hospital, major medical, group health, or medical insurance coverage in force that will not terminate prior to the effective date of this coverage?
- a) Will this plan replace existing coverage? (If Yes, the applicable replacement form must be signed.)
- b) When will existing coverage expire? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- Are you, your spouse, or any dependent, now pregnant?
- Have you, or any person to be insured been declined for insurance due to health reasons? (Not to be completed by residents of AZ, LA, NH, and OH)?
- Within the last five (5) years, have you, your spouse or any dependent to be covered, ever received any medical or surgical consultation, advice, or treatment including medication for: heart or circulatory system disorder including heart attack or chest pain; stroke; diabetes; cancer or tumor; immune system disorder including acquired immune deficiency syndrome (AIDS); alcoholism or alcohol abuse; drug abuse or chemical dependency?

Note: The plan cannot take effect prior to the termination date of existing coverage, or cannot be issued if YES is answered on any questions, 2-4. Under no circumstances can coverage become effective prior to the date this application is signed.

Monthly <input type="checkbox"/> _____ Days	Single Pay <input type="checkbox"/> _____ 30-185 Days	Deductible Amt. <input type="checkbox"/> \$250 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$500 <input type="checkbox"/> \$2,500	Rate of Payment After Deductible <input type="checkbox"/> 80/20 to \$5,000 Major Medical Plan <input type="checkbox"/> 50/50 to \$5,000 Limited Benefit Health (N/A in OK)	Total
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The undersigned applicant and the agent acknowledge (in Virginia, we certify) that the applicant has read, or has had read to him, the completed application. The applicant realizes that any false statement or misrepresentation in the application may result in claim denial or contract rescission. The applicant understands that any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. The applicant understands that the policy applied for will not pay benefits for any expenses incurred on account of any condition which manifested itself before the effective date. The applicant also understands that this is not a continuation of any previous medical plan, including any prior Short Term Medical plan.

X \_\_\_\_\_ Dorr R. Phelps  
 Insured's Signature                      Dated At                      Date                      Licensed Resident Agent's Signature  
 \_\_\_\_\_ 22042197001 \_\_\_\_\_ Dore R. Phelps  
 Agent Number                      Licensed Agent Name (Please Print)

Form 517-App

**Payment Method:**     Check or Discover     VISA / MASTERCARD

- When selecting monthly payment with Visa/Mastercard: I authorize Fortis Insurance Company to charge my credit card each month, for the Short Term Medical policy listed above, until the end of the policy or until I request cancellation. I understand I can request the charge be stopped if I notify Fortis Insurance Company 7 days in advance of the charge occurring. I also understand there will be no refund of premium after the 10-day free look period in the contract. The \$20 application fee is non-refundable.
- When selecting a single payment or Discover Card: I authorize Fortis Insurance Company to charge my credit card for the Short Term Medical policy listed above. I understand there will be no refund of premium after the 10-day free look period in the contract. The \$20 application fee is non-refundable.

Card Number \_\_\_\_\_ Expiration Date \_\_\_\_\_ / \_\_\_\_\_ Authorized Amount \_\_\_\_\_  
 Signature of Cardholder \_\_\_\_\_ Date \_\_\_\_\_

Agent Name: \_\_\_\_\_ Agent ID Number: \_\_\_\_\_ App Source: \_\_\_\_\_