

FOR HOSPITAL CONFINEMENT INDEMNITY COVERAGE UNDER GROUP POLICY FORM G-19000.

Policy Holder: **Value Benefits of America**

Applicant Name: (Last, First, M.I.) _____ Date of Birth: _____ Place of Birth: _____ Age: _____ Sex: _____ Height: _____ Weight: _____ Social Security Number: _____

Home Address: (Include number & street, city, state and zip code) _____ Mailing or Billing Address: (if other than Home Address) _____

Home Phone: _____ Work Phone: _____ Email Address: _____ Occupation: _____

DEPENDENT COVERAGE: I wish to apply for coverage for my following dependents:

Last, First, M.I.	Relationship:	Date of Birth:	Age:	Sex:	Ht:	Wt:	Social Security Number:
(1)							
(2)							
(3)							
(4)							
(5)							

BENEFITS BEING APPLIED FOR:

(check one)	<input type="checkbox"/> Silver Value Health USA	<input type="checkbox"/> Gold Value Health USA	<input type="checkbox"/> Platinum Value Health USA	<input type="checkbox"/> Silver Value Health Plan	<input type="checkbox"/> Gold Value Health Plan	<input type="checkbox"/> Platinum Value Health Plan
Physician's Office Benefits per Call.....	\$75	\$75	\$75	none	none	none
Daily Hospital Confinement Benefits.....	\$500	\$750	\$1,000	\$500	\$750	\$1,000
ICU / Coronary Care Unit Confinement Benefits.....	\$2,000	\$3,000	\$4,000	\$2,000	\$3,000	\$4,000
Maximum Emergency Accident Treatment Benefits.....	\$125	\$187.50	\$250	\$125	\$187.50	\$250
Maximum Ambulance Transportation Benefits.....	\$250	\$375	\$500	\$250	\$375	\$500
Maximum Anesthesiology Benefits per Schedule.....	\$2,000	\$3,000	\$4,000	\$2,000	\$3,000	\$4,000
Maximum Surgical Benefits per Schedule.....	\$10,000	\$15,000	\$20,000	\$10,000	\$15,000	\$20,000

I understand I am applying to be insured by the plan checked above. INITIALS: _____

REGARDING OTHER COVERSAGE:

PLEASE NOTE: THIS COVERAGE IS NOT MEANT TO BE A REPLACEMENT FOR COMPREHENSIVE BENEFITS UNDER A HEALTH INSURANCE PLAN OR HEALTH MAINTENANCE ORGANIZATION (HMO) PLAN AND THIS IS NOT A COMPREHENSIVE PLAN.

PREMIUM:

Insurance Premium \$ _____ plus Monthly Administrative Fee.

Payment Mode Monthly Bank Draft Monthly List Bill (2 or more) Quarterly Semi-Annual Annual

I HEREBY APPLY for coverage as indicated on this form. I have read or had read to me the completed form. To the best of my knowledge and belief, the answers to the questions contained in this application are true and complete.

WARNING: Any person who, 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 and may subject such person to criminal and civil penalties.

Dated at: _____ this _____ day of _____, 20 _____

Signature of Applicant: **X** _____ date signed _____

Print Agent's Name: _____ Agent's Number: _____

MEMBER'S QUALIFYING MEDICAL QUESTIONS

Member Name: _____

Spouse Name: _____

Child Name: _____

Child Name: _____

Child Name: _____

MEDICAL QUESTIONS

1. In the past 24 months, have you or your dependents, if applying for insurance, had chest pains, disease or disorder of the heart, liver, kidneys or lungs, high blood pressure, albumin or sugar in the urine, diabetes, cancer, tumors or ulcers? YES NO

2. Have you (or your dependents, if applying for insurance) consulted any physician or practitioner for any reason other than a routine physical exam with normal results, or been confined or treated in a hospital or similar institution during the past 24 months? YES NO

3. Please give details to any "Yes" answers, specifying person, condition, dates, treatment received and / or recommended and current status:

CURRENT OR APPLIED FOR COVERAGE

Are you now covered under, or awaiting issuance of, any accident or health insurance? YES NO

If "Yes", please list ALL accident and health coverages now in force or pending issuance (include coverage name and form number (if known), coverage type and benefit amount, and company name:

PLEASE NOTE: THIS COVERAGE IS NOT MEANT TO BE A REPLACEMENT FOR COMPREHENSIVE BENEFITS UNDER A HEALTH INSURANCE PLAN OR HEALTH MAINTENANCE ORGANIZATION (HMO) PLAN AND THIS IS NOT A COMPREHENSIVE PLAN.

I have read or had read to me the completed form. To the best of my knowledge and belief, the answers to the questions are true and complete.

Dated at: _____ this _____ day of _____, 20 _____

Signature of Member: **X** _____ date signed _____

I hereby certify that I saw the applicant and truly and accurately recorded the above information

Agent's Signature: **X** _____ date signed _____

Print Agent's Name: _____ Agent's Number: _____

HIPAA AUTHORIZATION

This Authorization was prepared by for purposes of obtaining information necessary to underwrite my (our) application(s) for insurance.

**The United States Life Insurance Company in the City of New York
A member company of American International Group, Inc.
830 Third Avenue, New York, NY 10022**

Value Benefits of America and its affiliates

I hereby authorize any licensed physician, medical practitioner, pharmacy benefit manager and other sources, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my health, to give to United States Life or its reinsurers and Value Benefits of America and its affiliates, any such information. Such information will pertain to my employment, or other insurance carrier or medical care, advice, treatment or supplies for any physical or mental condition. This includes that information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s). To facilitate the rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by United States Life to collect and transmit such information.

I understand that this information will be used by United States Life and Value Benefits of America and its affiliates solely to determine eligibility for insurance. I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action, which United States Life has taken in reliance upon this authorization. I understand this authorization will not be valid after 24 months from the effective date of coverage, if not revoked earlier. I know that I should retain a copy of this authorization for my records. I agree that a photocopy of this authorization is as valid as the original. To the best of my knowledge and belief, all statements made above are true and complete.

I understand that my application for group insurance will be accepted or declined on the basis of these statements. Insurance will take effect only if a certificate is issued based on this application and the first premium is paid in full (a) during the lifetime of all proposed insureds; and (b) while there is no change in the insurability or health of such person from that stated in the application.

(Print Please) Name of Applicant

Signature of Applicant and Date

Value Plans Consumer Form

Applicants purchasing the Value Health USA, Value Health or Hospital Plans must read & complete this form.

Please Print

Applicant's Name _____ **Agent's Name** _____

Applicant's Initials _____

1. The agent explained the provisions showing benefits, waiting periods, limitations and exclusions. I have received a Brochure for the plan for which I have applied. The agent advised me to read certificate of insurance if issued. _____

2. Are you presently enrolled in COBRA? Yes No
 - a. If yes, what date did you begin COBRA? _____
 - b. If yes, you need to know that you may have rights under the Health Insurance Portability and Accountability Act (HIPAA), to more comprehensive coverage that is not offered by these plans. Please contact your state's Department of Insurance for an explanation of these rights.
 - c. If yes, when does your COBRA terminate? _____

3. I understand that I may be eligible for insurance through a state health pool* or as a HIPAA eligible individual if I meet any of the following criteria:
 - a. have at least 18 months of creditable coverage without a significant break in coverage;
 - b. most recent coverage was under a group health plan, governmental plan or church plan;
 - c. not eligible for Medicaid or Medicare;
 - d. most recent coverage was not terminated due to non-payment of premium or fraud;
 - e. did not decline offer to continue coverage under a state program or under COBRA;
 - f. exhausted coverage under the elected continuation of coverage.**If you believe that you are an eligible person, you should contact your state's Department of Insurance for more information.** _____

4. I understand that this plan does not offer Major Medical coverage, and the Policy(s) I am purchasing may have limited benefits. I know that this policy(s) does not cover everything and that I will be responsible for the balance of these costs. _____

*AL, AK, AR, CO, CT, IL, IN, IA, KS, KY, LA, MN, MO, MS, MT, NE, NH, NM, ND, OK, OR, PA, SC, TX, UT, WA, WI, WY have high risk pools for eligible persons.

Applicant (Parent or Legal Guardian if Applicant is under 18)

Writing Agent

Signature

Signature

Agent #

Address

Print Name

City

State

Zip

Bank Authorization, Payment Calculation, VBA Membership Enrollment

Required with ALL new Value Health USA, Value Health Plan, Value Hospital Plan & Value Med Plan Applications.

(1) BANK DRAFT AUTHORIZATION AGREEMENT FOR AUTOMATIC MONTHLY PAYMENTS

I hereby authorize the indicated payee(s) below to charge my account the insurance premiums and fees due monthly.

- GEM ADMINISTRATORS (Value Health USA, Value Health Plan, Value Med Plan)
 UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA (UNL)
 (Value Med Plan in AR, ID, IL, MO, NE, NV, NM, ND, OK, SD, TX, UT & WV)
 GUARANTEE TRUST LIFE INSURANCE COMPANY (UNL)
 (Value Med Plan in approved states not listed above)

I understand my account will be charged once each month for the total amount shown as due for my monthly premium and fees for the term of the policy of insurance issued to me. I understand that if a charge to my account is not honored, my insurance coverage could lapse. I further agree that you will not be under any liability for any dishonored electronic withdraws from my account, for any reason, even though the dishonor results in the forfeiture of benefits or membership. If any ACH item is dishonored, I authorize any additional returned check fees resulting from said dishonored check, to be charged to my bank account. I understand that if I wish to cancel my coverage, I must inform the named insurance company above or GEM Administrators of such cancellation within 30 days of the withdrawal date. Please charge my monthly premium and fees against the following account.

Name of Depositor, as it appears on the Bank Institution's Records

Account Number Routing / Transit Number

Name of Banking Institution Branch

Address City State Zip

Please attach a voided check from the account you wish billed for your coverage

Authorized Signature Date Signed
MAKE CHECK(S) PAYABLE TO THE AUTHORIZED PAYEE INDICATED ABOVE

(3) PAYMENT CALCULATION

- A) INDICATE PAYMENT METHOD Annual[†]
 Monthly Bank Draft Monthly List Bill*
 Quarterly[†] Semi-Annual[†]

B) ENTER AMOUNTS	Value Health USA**	Value Health Plan**	Value Hospital Plan**	Value Med Plan**
1. Applicant	\$	\$	\$	\$
2. Spouse	\$	\$	\$	\$
3. Child (Rates are per child for USA, Health, and Hospital) # of children times amount per child =	\$	\$	\$	\$
4. VBA Monthly Fees: (VBA classic Membership is required if not a current VBA Member)***	Value Health USA Rates Include VBA Membership	\$5.00	\$5.00	\$5.00
5. Monthly Administration Fee	\$20.00	\$15.00	\$7.50	N/A
6. Total Monthly Due [†]	\$	\$	\$	\$
C) IMPORTANT PAYMENT INSTRUCTIONS	MAKE CHECK PAYABLE TO GEM ADMINISTRATORS			Make Check Payable to GTL or UNL

* Minimum for Monthly List Bill is 2 on Value Health or Value Hospital or 5 on Value Med.
 ** You can purchase only one AIG Product, either Value Health USA, Value Health or Value Hospital
 *** If you have purchased another level of VBA Membership, the \$5.00 monthly dues are waived.
 I have purchased another level of VBA Membership. Yes No
[†] For Quarterly, Semi Annual or Annual payment modes, see below:
 Value Health USA, Value Health or Value Hospital: Quarterly multiply total by 3, Semi-Annual multiply total by 6, and Annual multiply total by 12. VALUE MED PLAN: Quarterly, Semi-Annual - See brochure for rates (Add \$30 VBA dues if not already a member.) Annual - See brochure for rates.
 (Add \$60 VBA dues if not already a member.)
 VBA / Value Health USA / VHP / Value Hospital Plan / VMP FORM 281 (Revised 9/08)

(2) VALUE BENEFITS OF AMERICA CLASSIC MEMBERSHIP ENROLLMENT FORM*

Print Primary Member Name: _____

I agree to the Value Benefits of America terms and conditions as listed on this form

 Signature of Primary Member Date Signed

About Value Benefits of America Classic Membership:

Classic Benefits include over 400 major chains on-line in over 50 shopping categories, including everything from major department stores to specialty retailers to boutiques. In addition to earning rewards up to 25% shopping at participating on-line merchants, you can also receive point of sale discounts up to 50% from leading national retailers. Point of sale discounts are available on brand name merchandise, travel services and entertainment, including savings on movie tickets, movie rentals and at theme parks nationwide. You'll also enjoy savings of up to 60% dining at fine restaurants nationwide with discounted dining certificates, and the savings don't stop there. Included at no charge are discounts at over 55,000 pharmacies for your prescription drugs as well as lab tests and x-ray imaging services. Complete details of membership benefits are provided at www.VBAmembers.com.

*Classic Membership does not include Accident Medical, Emergency Air Ambulance or Accidental Death & Dismemberment Benefits.

VBA Terms & Conditions

- Member understands that VBA is not an insurance company or program. Accident Benefit Payments are made by the administrator for the insurance company issuing the blanket coverage to Members.
 - VBA provides savings to its members on services through a number of sources. The current list of benefits may be modified through additions or deletions. A quarterly newsletter, posted on our website or sent via e-mail, will keep Members up to date on benefits and other pertinent information.
 - Payments for the VBA Program are due in advance. Payments will be drafted on or about 15 days before the due date. If you choose to cancel your program, it is your responsibility to make sure that your membership card and a written request for cancellation are sent to VBA at least 15 days prior to the anniversary of your effective date in order for your account not to be charged for additional fees.
 - Member hereby appoints, Value Benefits of America Association (VBA) President or failing this person, a VBA Director, as proxy holder for and on behalf of the member with the power of substitution to attend, act and vote for and on behalf of the member in respect of all matters that may properly come before the meeting of the members of VBA and at every adjournment thereof, to the same extent and with the same powers as if the undersigned member were present at the said meeting, or any adjournment thereof. Annual meetings are to be held in Arizona the second Tuesday of August.
 - VBA reserves the right to terminate any enrollment or deny eligibility in the program for lack of payment to VBA. Returned checks, insufficient notices on bank drafts or denial by the member's credit card company for payment of the membership fee is deemed to be evidence of non-payment by a member. There will be a \$10.00 charge to be reinstated in the program after such denial. If reinstatement for non-payment happens more than once, a \$20.00 reinstatement will apply.
 - In the event of any dispute, member agrees to resolve said dispute solely by binding arbitration that shall be governed by the laws of the state of Arizona and enforceable at Scottsdale, Maricopa County.
 - Membership cancelled within the first 30 days of the enrollment date may be eligible for refund if the membership card and written cancellation request are sent to VBA. The administrative fee is not refundable. Approved refunds will be processed approximately 30 days after cancellation.
 - Membership is effective on the 1st of the month following enrollment acceptance by VBA.
- Member Agreement:** By signing the enrollment form, Member expresses desire to become a member of Value Benefits of America. Member acknowledges that the discount plans ARE NOT INSURANCE, but membership may include certain limited supplemental insured coverage's. Membership benefits are not a replacement for health insurance coverage nor are they intended as a substitute for health insurance coverage. Membership fees may be changed for all members, but not individually, with notification.

Please mail completed forms and your check(s) to:

VALUE BENEFITS OF AMERICA
 15575 N. 79TH PL. #100 (2ND FLOOR)
 SCOTTSDALE, AZ 85260

Marketed By:

GAC#: