Value Health Plan

Sickness & Accident, Hospital/Surgery For Individuals, Families and Groups

- **NO DEDUCTIBLE OR CO-PAYS**
- **USE ANY HOSPITAL OR DOCTOR**
- **HOSPITAL BENEFIT TO $1,000 PER DAY**
- **INTENSIVE CARE TO $4,000 PER DAY**
- **SURGERY BENEFIT TO $20,000**
- **ANESTHESIOLOGIST BENEFIT TO $4,000**
- **BENEFITS PAID DIRECTLY TO YOU**
- **ISSUE AGES 0 TO 64**

AIG American General

Form VHP-1

VALUE HEALTH PLAN

Sickness & Accident, Hospital/Surgery

MEDICAL BENEFITS SCHEDULE

BENEFIT DESCRIPTION	DEDUCTIBLE	CLASSIC MAXIMUM BENEFIT	SILVER MAXIMUM BENEFIT	GOLD MAXIMUM BENEFIT	PLATINUM MAXIMUM BENEFIT
HOSPITAL BENEFITS					
Daily hospital confinement from the 1st day up to 1 year per hospital confinement due to sickness or injury	**NONE**	**$250.00**	**$500.00**	**$750.00**	**$1,000.00**
Daily intensive care INCLUDES hospital confinement benefit up to 30 days per sickness and accident	**NONE**	**$1,000.00**	**$2,000.00**	**$3,000.00**	**$4,000.00**
SURGICAL BENEFITS					
Pays scheduled amount for surgery due to sickness or injury	**NONE**	**$5,000.00**	**$10,000.00**	**$15,000.00**	**$20,000.00**
Pays schedule expenses for administration of anethesia during a covered surgery	**NONE**	**$1,000.00**	**$2,000.00**	**$3,000.00**	**$4,000.00**
EMERGENCY BENEFITS					
Pays expenses incurred for emergency treatment due to an injury	**NONE**	**$62.50**	**$125.00**	**$187.50**	**$250.00**
Pays expenses incurred for ambulance services due to sickness or injury	**NONE**	**$125.00**	**$250.00**	**$375.00**	**$500.00**

ISSUE AGE UNISEX RATES

AGE	MONTHLY CLASSIC	MONTHLY SILVER	MONTHLY GOLD	MONTHLY PLATINUM
CHILD	**$10.00**	**$20.00**	**$30.00**	**$40.00**
19-39	**$20.00**	**$40.00**	**$60.00**	**$80.00**
40-49	**$25.00**	**$50.00**	**$75.00**	**$100.00**
50-59	**$37.50**	**$75.00**	**$112.50**	**$150.00**
60-64	**$45.00**	**$90.00**	**$135.00**	**$180.00**

Add $15.00 monthly administration fee per certificate.

This brochure is a brief summary of benefits only and is subject to the terms, conditions, exclusions and limitations of Group Policy No. G-610,090, Form No. G-19000. Coverage may vary or may not be available in all states.

Q&A

Do rates go up due to age increase? No

Who is eligible for coverage?
Any eligible individuals under age 65 and their dependents who are VBA Members.

Who are eligible dependents?
Your spouse under age 65 and your dependent children under the age of 19 or under the age of 25 if they are a full time student.

What are the medical requirements to enroll in the plan?
Simply answer a few "yes/no" questions on the application form. There is no medical exam required.Issuance of a Certificate of Insurance or payment of benefits may depend upon the answers given in the application and the truthfulness thereof.

Do I have to pay deductibles and co-pays under this plan?
No, this plan is designed to pay the first dollar of covered expenses for the member and all the member's enrolled dependents up to the limits of the plan option selected.

When does coverage begin?
Coverage will begin on the first of the month following approval of the application and receipt of the first modal premium.

Can I use any doctor or hospital?
Yes, you may use any doctor or hospital of your choice.

Are pre-existing conditions covered?
After your policy has been in effect for more than 12 months, pre-existing conditions are covered

What is a pre-existing condition?
Any condition you have now or had within a 12 month period prior to the effective date of coverage for each insured person

For VBA Members

Value Benefits of America, Inc. (VBA)

A Not-For-Profit Association

Exclusions and Limitations

PRE-EXISTING CONDITIONS PROVISIONS FOR MEDICAL CARE BENEFITS

PRE-EXISTING CONDITION means an injury or sickness for which a person: incurred charges received medical treatment consulted a physician, or took prescribed drugs within 12 months before he became insured under a given benefit section of the group policy. In spite of any other provision of the group policy: No benefits will be paid under a benefit section for charges incurred for a pre-existing condition **until:**

1. the person has not: incurred charges received medical treatment consulted a physician, or taken prescribed drugs for such condition, or any complication of it, for 12 continuous months, while insured; or

2. the person stays insured under such benefit section for 12 continuous months.

GENERAL EXCLUSIONS

No medical care benefits will be paid by the group policy for charges incurred for treatment which:

1. is given after a person's insurance ends, regardless of when the injury or sickness occurred. However, medical care benefits may be provided in the Benefits After Insurance Ends provision of a given benefit section.

2. is not essential for the necessary care or treatment of the injury or sickness involved.

NECESSARY CARE OR TREATMENT means that a treatment, service, supply, or medicine: is appropriate and essential for the diagnosis or treatment of the person's symptoms; is within the scope, duration or intensity of that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; is furnished within the framework of generally accepted methods of medical treatment; involves only the use of any drugs or substances formally approved by the United States Food and Drug Administration.

A treatment, service, supply or medicine will ***not*** be considered NECESSARY CARE OR TREATMENT if it is: part of a treatment plan that is determined to be an Experimental Procedure or for research purposes; or provided primarily as a convenience to the patient, the patient's family or the provider of care.

EXPERIMENTAL PROCEDURE means any medical procedure, equipment, treatment or course of treatment, or drugs or medicines that are: limited to research; not proven in an objective manner to have therapeutic value or benefit; restricted to use by medical facilities capable of carrying out scientific studies; of questionable medical effectiveness; or would be considered inappropriate medical treatment.

To determine whether a procedure is experimental, United States Life will consider, among other things, commissioned studies, opinions and references to or by the American Medical Association, the Federal Food and Drug Administration, the Department of Health and Human Services, the National Institutes of Health, the Council of Medical Specialty Societies and any other association or program or agency that has the authority to review or regulate medical testing or treatment.

3. would be given free of charge if the person was not insured.

However, medical care benefits **will be paid** for covered charges incurred by a state for medical assistance to an insured person under Title XIX of the Social Security Act of 1965.

4. results from a war or an act of war.

5. results from intentionally self-inflicted injury.

6. Is given by a person's spouse or his or his spouse's parents, children, grandparents, grandchildren, sisters, brothers, aunts, uncles, nieces or nephews.

The policy described in this brochure provides limited benefits only, which are less than the minimum standards for benefits for major medical expenses coverage as prescribed by the insurance regulatory authority of your state.

Be sure to review your certificate completely when you receive it.

MAIL APPLICATIONS TO:
Value Benefits of America
15575 N. 79th Pl – #100
Scottsdale, AZ 85260
800-366-2467

Administrator:
GEM Administrators
919 N. 1st St
Phoenix, AZ 85004
800-756-4906

__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, New York 10022

The United States Life Insurance Company in the City of New York

A member company of American International Group, Inc.

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

Policy Holder:	**Value Benefits of America**						
Applicant:	Date of Birth:	Place of Birth:	Age:	Sex:	Ht	Wt	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:

First, Middle and Last Name	Date of Birth	Age	Sex	Ht	Wt	Social Security No.	Relationship

BENEFITS BEING APPLIED FOR:

(check one)	❑ Classic	❑ Silver	❑ Gold	❑ Platinum
Daily Hospital Confinement Benefits per day	$250	$500	$750	$1,000
Daily Intensive Care/Coronary Care Unit Confinement Benefits	$1,000	$2,000	$3,000	$4,000
Maximum Emergency Accident Treatment Benefits	$62.50	$125	$187.50	$250
Maximum Ambulance Transportation Benefits	$125	$250	$375	$500
Maximum Surgical Benefits Per Schedule	$5,000	$10,000	$15,000	$20,000

QUALIFYING 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, uncontrolled high blood pressure, albumin or sugar in the urine, uncontrolled diabetes, cancer, tumors or ulcers? ❑ Yes ❑ No
2. For conditions not listed in #1, have you or your dependents, if applying for insurance, during the past 12 months, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution? ❑ Yes ❑ No
3. Please give details to any "Yes" answers, specifying person, condition, dates, treatment received and/or recommended and current status:____
____
__________________________(Attach additional signed & dated sheet if more room needed.)

OTHER COVERAGE:

1. 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:____________________
__________________________(Attach additional signed & dated sheet if more room needed)
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.
2. Will any existing coverage be replaced by the coverage you are applying for? ❑ Yes ❑ No
If "Yes", please give company name, type of coverage and policy number:____________________

PREMIUM:

Insurance Premium $____________ plus $15.00 Monthly Administrative Fee

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

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

I UNDERSTAND AND AGREE that: (1) this coverage will be granted solely and entirely in reliance upon my answers to the questions contained in this application; (2) no coverage will exist until a Certificate of Coverage is issued, and will be in force only as of the Certificate Effective Date; (3) any misstatement of fact in this application may result in the denial of benefits or cause the Company to change or rescind my coverage; (4) any loss for a condition for which medical advice or treatment was received from a doctor during a twelve month period prior to the date of this application, will not be covered until my coverage has been in force for 12 months.

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 ____________________

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

Agent's Signature: **X** ______________________________ date signed ____________________

Print Agent's Name ______________________________ Agent's Number(s) ________**_(ISA-113641)**

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

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 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 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

Required with all new Value Health, Value Hospital & Value Med 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 or VALUE HOSPITAL PLANS)**

☐ **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 (GTL) (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 Institutions Records

Account Number Routing / Transit Number

Name of Banking Institution Branch

Address City Sate Zip

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

X____________________ Date Signed:__________

MAKE THE CHECK (S) PAYABLE TO THE AUTHORIZED PAYEE INDICATED ABOVE.

(3) PAYMENT CALCULATION

A) INDICATE PAYMENT METHOD:	☐ Monthly Bank Draft	☐ Monthly List Bill *	☐ Semi-Annual**** ☐ Annual ****
B) ENTER AMOUNTS:	Value Health Plan **	Value Hospital Plan **	Value Med Plan **
1. Applicant	$	$	$
2. Spouse	$	$	$
3. Child (Rates are per child for the Value Health /Hospital) # _____ X $ _____ =	$	$	$
4. VBA Monthly Fees: (VBA Classic Membership is required if not a current VBA member) ***	$5.00	$5.00	$5.00
5. Monthly Administration Fee:	$15.00	$7.50	NA
6. Total Monthly Due: ****	$	$	$
C) IMPORTANT PAYMENT INSTRUCTIONS:	Make check payable to GEM Administrators.	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 the Value Health or the Value Hospital.
You can purchase the Value Med alone or with either the 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 Semi Annual or Annual payment modes, see below:**
VALUE HEALTH or VALUE HOSPITAL: **Semi-Annual** - Multiply total by 6. **Annual** - Multiply total by 12.
VALUE MED PLAN: 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.)

(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.

X____________________ __________

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 online 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 ww.VBAmembers.com.

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

VBA Terms and Conditions:

1. 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.
2. 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.
3. 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.
4. 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.
5. 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.
6. 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.
7. 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.
8. 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 PLACE, SUITE 100
SCOTTSDALE, AZ 85260

Marketed By: GAC #:

Consumer Form

Each applicant who purchases one of the following: Hospital Indemnity, Hospital/Surgical, Surgical, or Limited Benefit Medical Plan must complete and sign this form. Please indicate below which plan was purchased and submit this form with the application.

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 or an Outline of Coverage for the policy(s) for which I have applied. The agent advised me to read the policy when issued. ____________

2. Are you presently enrolled in COBRA?
   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. Is your current coverage terminating due to the expiration of COBRA? ❑ Yes ❑ No
   If yes, attach a copy of your COBRA termination letter to the application. ____________

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 these plans do 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)*

____
Signature

____
Address

____
City ***State*** ***Zip***

Writing Agent

____
Signature ***Agent #***

____
Address

____
City ***State*** ***Zip***

VALUE HEALTH / HOSPITAL PLANS

Underwritten by The United States Life Insurance Company in the City of New York (AIG)

AGENT GUIDELINES

1. ISSUE DATE: If money is received with business by the 10th, the effective date will be15th and if it is received between the 11th and 25th it is effective the 1st of the following month. You can request a later effective date with a note attached to the application.
If no money is received than we must receive it by the 5th for an effective date of 15th or by the 20th for an effective date of the 1st.
2. MONIES COLLECTED: Make checks payable to GEM Administrators. Applicants can pay by Monthly Bank Draft, Semi-Annual, Annual or Monthly List Bill. Make sure the applicant is aware that their account will be drafted immediately if they did not submit money and thereafter (after issuance) approximately 15 days prior to the due date.
3. ORIGINAL APPLICATION(S) ARE PREFERRED: We do accept legible fax/photo copies. If not legible, issue is delayed for the original.
4. MUST INCLUDE THESE SIGNED FORMS: HIPAA Authorization, VBA membership enrollment, Automatic Monthly Bank Draft (and voided check) and the Consumer Form (only on Value Health Plan).
5. CONTACT INFORMATION: Most correspondence regarding application is sent to the agent via email, phone or mail. We may be required to call on the customer, so always include the email address, if available and the phone number.
6. LIST BILL: No group participation and a minimum of 2 or more employees must apply. The 1st month's premium and fees must be paid to issue on a List Bill. *Please use the GEM Administrators List Bill Form. (Call for special UW consideration for groups of 5 or more)*
7. COMMISSION PAYMENT: New business will be paid weekly upon issue and renewals on or about the 20th of each month.
8. CHANGES AND CANCELLATIONS: Any changes, including cancellations (administrative fees are non-refundable) must be in writing and sent to: GEM Administrators ▪ 919 N 1st St ▪ Phoenix, AZ 85004 ▪ Phone: (800) 756-4906
9. FULFILLMENT: All fulfillment information, Certificate of Insurance and ID cards will be mailed directly to your client.
10. CHILD ONLY COVERAGE: When applying for child only coverage, you must charge the "19 year old adult rate" for the oldest child, then charge the child rate for younger dependent children in the same family (children are considered dependents if under age 19 or age 25 and a full time student). If you are writing one child only, you must charge the "19 year old" adult rate. Complete the Enrollment Form with the parent listed as the "Name of Member/Applicant". Write in after the parent's name, "Not To Be Covered". Complete all other sections of the application as normal.
11. COVERAGE REPLACEMENT: The applicant must list the reason coverage is being replaced.

FEMALE			MALE		
Height	Min Weight	Max Weight	Height	Min Weight	Max Weight
4′8″	77	212	5′0″	91	234
4′9″	78	216	5′1″	93	237
4′10″	79	220	5′2″	95	243
4′11″	81	224	5′3″	98	247
5′0″	83	229	5′4″	101	256
5′1″	85	238	5′5″	103	262
5′2″	87	243	5′6″	106	270
5′3″	89	244	5′7″	109	276
5′4″	91	250	5′8″	112	286
5′5″	93	256	5′9″	115	296
5′6″	96	262	5′10″	118	299
5′7″	98	268	5′11″	121	308
5′8″	101	274	6′0″	124	312
5′9″	104	287	6′1″	127	323
5′10″	107	288	6′2″	131	328
5′11″	110	296	6′3″	134	339
6′0″	114	305	6′4″	138	360
6′1″	117	314	6′5″	142	385
6′2″	120	323	6′6″	146	409
			6′7″	150	418
			6′8″	154	427

UNDERWRITING GUIDELINES

The applicant and spouse height and weight must be within the guidelines listed on the chart. The most common medical conditions that are underwriting declines are:

Within 2 years, the following are declines: Kidney Dialysis, AIDS or HIV, Internal Cancer, Melanoma, Alzheimer's Disease, Lupus, Uncontrolled Diabetes, Uncontrolled High Blood Pressure, Heart Attack, Stroke, Emphysema, COPD, Leukemia, Parkinson's Disease, Drug or Alcohol Abuse, Multiple Sclerosis, Muscular Dystrophy, Anyone who has received Home Health Care or been confined in a Nursing Home or similar institution or been hospitalized for a major cause.

There are no rate ups and no eliminations!

These are general rules, other conditions disclosed on the application may cause a decline. Underwriting decisions are made based on the information disclosed on the application for insurance. Any false or incomplete information listed on the application can result in a rescission within the first 2 years of coverage.

Call if special underwriting consideration is needed for your group.

Questions or Supplies: Call GAC National Marketing Division

1-800-981-VALU (8258) ▪ Fax: 1-775-256-3023

Email: jomarie@GeneralAgentCenter.com

or jomarie123@aol.com

Address: 23839 Coral Ridge Lane, Land O'Lakes, FL 34639