



BMC DesignMED New Business Submission Worksheet

Applicants Name _____

Hours worked per week _____

Applicant's Employer _____

Time with Company _____

Applicant's Occupation / Duties _____

**CO, IL, IA, MI,
MS, MO, NE, NV,
NM, OH, OK, SC,
SD, TX, UT, WY**

Monthly DesignMED premium \$ _____
 Monthly Administration Fee..... \$ **8.00**
 Total Monthly Premium..... \$ _____
 ONE TIME ONLY application FEE \$ **20.00**
 TOTAL, first Check \$ _____

*I wish to apply
for coverage for:*

- Myself**
- Myself & Spouse**
- Myself & Children**
- Family**

As a convenience to me, please draft my bank account for the initial premium and one time only \$20 application fee shown above as "Total first check". After that, the monthly draft amount should be the amount listed by "Total monthly premium", above. The authorization for Monthly Bank Draft must also be completed and signed in order to receive this service.

Applicant's Signature

Date

Please CIRCLE the premium amount (below) that corresponds to your requested coverage. Only one of these HI plans may be purchased.

Emp Emp/SP Emp/Ch Family

COMPLETE	\$130.34	\$258.18	\$214.49	\$342.33
Cat Combo	\$59.50	\$119.00	\$104.50	\$164.00
Super Supp	\$24.77	\$49.53	\$40.10	\$64.87
Super Supp Plus	\$30.77	\$61.53	\$51.10	\$81.87

Premium Calculations:

- 1) Determine those desiring coverage, above
- 2) Determine premiums, below left
- 3) Insert appropriate premium, above left
- 4) Application fee is ONCE ONLY!
- 5) "Monthly Premium" is renewal premium

Please submit applications to:

BMC DesignMED

**1529 Sam Rittenberg Blvd., Suite 200
Charleston, S.C. 29407**

I understand that the Premium for the plan that I have selected is \$ _____ per month. To keep my insurance in force, this amount must be submitted on a monthly basis by authorization of a BANK DRAFT.

BMC DesignMED, 1529 Sam Rittenberg Blvd, Suite 200, Charleston, S.C. 29407

Signature of Applicant X _____



BMC *DesignMED* CONSUMER UNDERSTANDING FORM

Each applicant applying for any of the following **BMC *DesignMED*** plans underwritten by Assurity Life Insurance Company must complete and sign this form. Indicate plan below and include this form with the application.

- DesignMED* COMPLETE** ***DesignMED* Cat Combo**
 ***DesignMED* Super Supp** ***DesignMED* Super Supp Plus**

Applicant's Name _____ Agent's Name _____ Date: ___ / ___ / ___
Please Print name.

1) The above referenced agent visited with me in reference to making application for insurance with your company. The soliciting agent explained the provisions showing benefits, waiting periods, limitations, and exclusions. I have received an outline of coverage for the policy(s) for which I applied.

Applicant's Initials _____

2) I understand that **BMC *DesignMED*** plans are **NOT** Major Medical policies, and the policy(s) I am purchasing have limited outpatient coverage and doctor benefits. I know that this policy(s) will not cover everything, and that I will be responsible for some costs.

Applicant's Initials _____

3) I understand that I will not have insurance coverage with Assurity Life Insurance Company until my application(s) has been approved and the Company has notified me that I have been accepted for coverage with a particular effective date. I also understand that in order to receive consideration under a "Guarantee-to-Issue" basis that I must be gainfully employed and working a minimum of 30 hours per week at the time of application.

Applicant's Initials _____

4) I understand that I may not be accepted for insurance by Assurity Life Insurance Company, or may be accepted but may have an exclusionary rider for particular medical conditions, and that conditions for which I have sought or received treatment or manifest symptoms in the 36 months prior to my application date will not be covered until 12 months after my policy effective date if completely disclosed on the application, and after 24 months if not completely disclosed on the application, and that I should not let any other coverage lapse until I have received and reviewed the Assurity Life Insurance Company individual policy(s) in my name and found them to be suitable to my needs.

Applicant's Initials _____

5) I affirm and certify that all questions on the application(s) have been truthfully and completely answered. I have fully disclosed all health history on myself or any other family members listed on the application(s). I understand that this agent has no authority to waive or modify any answer to any health question.

Applicant's Initials _____

Applicant's Signature _____
Applicant's Address _____
City, State, Zip _____

Agent's Signature _____
Agent's Address _____
City, State, Zip _____

Assurity Life Insurance Company



www.assurity.com
 1-866-289-7337
 P.O. Box 80926
 Lincoln, Nebraska
 68501-0926

APPLICATION FOR INSURANCE

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a substantial civil penalty where and to the extent allowed by state law.

Application must be completed and signed in black ink.

PART A - THIS SECTION MUST ALWAYS BE COMPLETED.

1. Proposed Insured (Employee)

Male Female _____
 (Last) (First) (MI)

Address _____

City _____ ST _____ Zip _____ Home Phone # (____) _____ - _____

Base Monthly Salary _____ Occupation/Job Description _____

Employer _____ Dept# _____ Hire Date ____/____/____ Birth Date ____/____/____ Issue Age _____
 Mo/Day/Yr Mo/Day/Yr

Social Security Number _____ - _____ - _____

Have you used ANY form of Tobacco within the last twelve- (12) months? Yes No

Beneficiary (full name and relationship) _____
 Primary Contingent

Owner, if other than Proposed Insured (Employee) _____
 Name Relationship Address if other than above

Dependent's Insurance: (NOTE: The beneficiary of dependent's insurance is in all cases the Proposed Insured (Employee))

Name: (First-MI-Last)	Date of Birth (Mo/Day/Yr)	Issue Age	Relationship To Proposed Insured (Employee) (Spouse)
_____	_____	_____	(Spouse)
_____	_____	_____	(Child)
_____	_____	_____	(Child)
_____	_____	_____	(Child)
_____	_____	_____	(Child)

2. Have any persons to be insured consulted a Physician, received medical treatment of any kind, been disabled or hospitalized in the past three years? (If Yes, complete # 7) Yes No

3. Have any persons to be insured ever been medically diagnosed or treated as having "AIDS" (Acquired Immune Deficiency Syndrome), AIDS Related Complex (ARC), or Antibodies to Human T-lymphotrophic Virus Type III (HTLV) prior to today? Yes No

4. During the past six months, has the Proposed Insured (Employee) been limited in performing normal activity in a job for 30 hours or more per week? Yes No

5. **For Cancer and Specified Disease Applicants ONLY:** All Persons to be insured are not now nor ever have been treated nor diagnosed for cancer or any malignancy or the following diseases: Addison's Disease, Botulism, Brucellosis, Budd-Chiari Syndrome, Cystic Fibrosis, Diphtheria, Encephalitis, Histoplasmosis, Legionnaire's Disease, Lou Gehrig's Disease, Lupus Erythematosus, Malaria, Meningitis, Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Osteomyelitis, Polio, Q Fever, Reye's Syndrome, Rheumatic Fever, Rocky Mountain Spotted Fever, Sickle Cell Anemia, Tay-Sachs Disease, Tetanus, Toxic Shock Syndrome, Trichinosis, Tuberculosis, Typhoid Fever, Whooping Cough except [enter name(s)] (if none, state "NONE"). _____ The person named above will be excluded in part or in total from coverage by an Elimination Rider to be signed by the applicant before policy issuance.

6. **For Hospital Intensive Care Rider Applicants ONLY:** All Persons to be insured are not now nor ever have been diagnosed nor treated as a victim of a heart attack, heart condition, heart trouble, nor any abnormality of the heart, prior to this date except [enter name(s)] who is/are to be excluded (if none, state "NONE") _____ from coverage for any intensive care confinement resulting from any disorder of the heart, and shall be limited to three days coverage in connection with any other intensive care confinement. The person named above will be excluded in part or in total from coverage by an Elimination Rider to be signed by the applicant before policy issuance.

7. Explanation for #2. Give details including name, dates, diagnosis, outcome, name and dosage of medications taken and Physician's Address/Phone. Use additional sheets of paper if necessary. The Proposed Insured (Employee) must sign each additional sheet and the agent must sign as witness.

Person to be Insured (First-MI-Last)	Relationship to Proposed Insured (Employee)	Question #	Explanation	Physician/Address/Phone #

8. Has the Proposed Insured (Employee), if eligible for or covered by Medicare, received a copy of:
 a) the "Guide to Health Insurance for People with Medicare"? Yes No
 b) the "Medicare Duplication Acknowledgement Form"? Yes No

9. **INSURED'S STATEMENT:** Will the policy applied for replace or change any insurance or annuities in force on the life of any person to be insured? (If Yes, give name of company, policy number being replaced/ changed and enclose any required state replacement forms.) Yes No

10. **AGENT'S STATEMENT:** Does this insurance replace or change any existing insurance or annuities? Yes No
 If YES, and if required, is replacement form completed and attached?
 If NO, give details _____

All Applicants

I have read the answers and statements written in this application, and represent each and all of them to be true and complete to the best of my knowledge and belief. In the absence of fraud, my answers in this application shall be deemed representations and not warranties. I agree that a copy of this application and any supplement shall be attached to and form a part of any policy issued. Acceptance of any insurance policy issued on this application will constitute a ratification of any corrections or additions to the application noted by the Company in the space headed "HOME OFFICE CORRECTIONS OR ADDITIONS" for administrative purposes. A photostatic copy of the amended application attached to the policy will be sufficient notice of such corrections or additions.

The insurance applied for shall be in force as of the date of the Proposed Effective Date, provided that the Company approves the application without any modification as to the plan, amount or premium, and, further provided that the Company receives the first premium payment from my employer within 90 days from the date of the payroll deduction authorization signed by me. If the first premium is not received within 90 days, no insurance will become effective. If the application is approved with any such modification, the insurance shall not take effect until the policy has been delivered to and accepted by me and shall not take effect if there has been a change in the health of any person to be insured as stated since the date of the application.

I certify that I have received the Outline of Coverage.

The employee will be the owner unless otherwise stated.

Applicants of PART B

I acknowledge receipt of the notice regarding the Medical Information Bureau and consumer reports detached from this application. I authorize any licensed physician, medical practitioner, 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, or that of my family members, to give to Assurity Life Insurance Company or its reinsurers any such information. This authorization extends to and includes information or records pertaining to psychiatric, drug or alcohol use history. I authorize Assurity Life Insurance Company to obtain an investigative consumer report on my spouse or me. **A photocopy or an electronic similarity of this authorization shall be as valid as the original. AS AN EMPLOYEE, working a minimum of at least 30 hours per week for this employer, I agree that I have selected the products indicated above, and understand the total monthly premium will be deducted from my paycheck.**

Home Office corrections and additions only

Proposed Effective Date: _____		Group Number: _____	
Signed at (city & state)	Date	Signature of Proposed Insured (Employee)	
(____)Percentage	Licensed Agent	Signature of Owner (If other than Proposed Insured Employee)	
(____)Percentage	Licensed Agent	Signature of Interpreter (If Required by Proposed Insured Employee)	

NOTICE REGARDING REPLACEMENT OF YOUR LIFE INSURANCE POLICY OR ANNUITY

Are you thinking about buying a new life insurance policy/annuity and discontinuing/ changing an existing one? If so, your decision could be a good one or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits. Make sure you understand the facts. Ask the company or agent that sold you your existing policy to give you information about it. Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest. We are required by law to notify your existing company that you may be replacing their policy.



If you would like to enjoy the convenience of automatic billing to your checking or savings account, simply fill out all of the information below. Upon approval, we will then electronically transfer funds from the designated account for amounts due.

Authorization to Honor Drafts Drawn by And Payable to:

BDG Benefits Design Group or BMCDesignMED
19009 Preston Road, Suite 215-236
Dallas, TX 75252

As a convenience to me, I hereby request and authorize you to pay and charge to my bank checking account drafts drawn by and payable to the order of BDG Benefits Design Group or BMCDesignMED provided there are sufficient collected funds in said account to pay the same upon presentation. It will not be necessary for any other employee of BDG Benefits Design Group or BMCDesignMED to sign such drafts. I agree that your rights in respect to each such draft shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring such draft.

I further agree that if any such draft be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Name as shown on bank account Social Security Number

Financial Institution Branch

City State Zip

Routing/Transfer Number Account Number Checking or Savings Account

Signature of Premium Payor(s)—Give both signatures if Joint Account

**ATTACH SAMPLE
PERSONAL CHECK**

Mailing Address: Street City State Zip

() _____
Daytime Phone Number

To the Bank named above:

So that you may comply with your depositor's request, BDG Benefits Design Group agrees:

- (1) To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed or issued by or on behalf of the undersigned, and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
- (2) To indemnify you for any loss in the event that any such check, draft or order shall be dishonored whether with or without cause, and whether intentionally or inadvertently, even though such dishonor results in a forfeiture of the insurance.
- (3) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your action taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.