

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

GUARANTEED RENEWABLE TO AGE 75

VALUE HEALTH PLAN

Sickness & Accident, Hospital/Surgery

MEDICAL BENEFITS SCHEDULE

HOSPITAL BENEFITS					
BENEFIT DESCRIPTION	DEDUCTIBLE	OPTION 1 MAXIMUM BENEFIT	OPTION 2 MAXIMUM BENEFIT	OPTION 3 MAXIMUM BENEFIT	OPTION 4 MAXIMUM BENEFIT
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 including hospital confinement benefit up to 30 days per sickness or injury	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 anesthesia 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 OPTION 1	MONTHLY OPTION 2	MONTHLY OPTION 3	MONTHLY OPTION 4
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.

The information contained in this brochure is a brief summary of benefits and is subject to all exclusions, limitations and exceptions set forth in the certified coverage.

Q & A

Do rates go up due to age increase? No

Who is eligible for coverage?

Any eligible individuals and their dependents who are Premier Members of Value Benefits of America Association under the age of 65.

Who are eligible dependents?

Your spouse 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 enrollment form. There is no medical exam required.

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.



How long can I keep the coverage?

The coverage is guaranteed renewable to age 75 regardless of your health condition. Benefits reduce at age 65.

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 Premier Members

**Value
Benefits**
of America, Inc. (VBA)
A Not-For-Profit Association

Exclusions and Limitations

PRE-EXISTING CONDITIONS LIMITATION: The benefits of this Policy will not be payable during the first 12 months that coverage is in force with respect to an Insured Person for a loss caused by a Pre-Existing Condition. This 12-month period is measured from the effective date of coverage for each Insured Person.

A Pre-Existing Condition means a Sickness first manifested or Injury sustained or any condition for which medical advice or treatment was recommended by or received from a Physician within a 12-month period prior to the effective date of coverage for each Insured Person.

If this coverage is intended to replace coverage under another group contract, only those Pre-Existing Conditions excluded by the replaced group contract will be subject to exclusion under this coverage.

WHAT WE WILL NOT PAY FOR: This Policy does not cover any Sickness or Injury that is the result of:

- (1) war or any act of war (declared or undeclared);
- (2) The Insured Person's participation in a felony, riot or insurrection;
- (3) service in the armed forces or units auxiliary thereto of any country, and in such event We will refund any portion of the unearned premium due the Insured Person upon entrance into such military service;
- (4) routine dental care, including the removal of impacted wisdom teeth, unless due to an Injury to natural teeth;
- (5) nervous or mental disorders without demonstrable organic disease;
- (6) normal pregnancy and childbirth; complications of pregnancy however will be treated as any other Sickness;
- (7) attempted suicide (while sane or insane) or any intentionally self-inflicted Injury; or
- (8) the Insured Person being intoxicated or under the influence of alcohol or a narcotic, unless administered on the advice of a Physician.

Coverage is not provided for any loss covered under a state or federal worker's compensation, state disability, employer's liability or occupational disease law or no-fault automobile insurance policy.

Coverage is not provided for confinement in:

- (1) a government Hospital (unless otherwise required by law); or,
- (2) a Hospital located outside of the territorial limits of the United States of America, its commonwealth partners, or the countries of Canada and Mexico.

Under the Surgical Benefit, coverage is also not provided for:

- (1) dental, cosmetic or plastic surgery, except as necessary to repair or alleviate damages to the natural body and caused solely by a covered Injury; or
- (2) pregnancy, abortion, or childbirth, except a Complication of Pregnancy.

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

Coverage is being provided under a group policy issued in the State of Missouri Group Policy Number WLIC-HIP-03

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

**Application to WESTWARD LIFE INSURANCE COMPANY, Lakewood, CA
For Hospital Confinement Indemnity Coverage under Group Policy Form WLIC-HIP-03 MGP
For Members of Value Benefits of America**

1. Name of Member/Applicant: _____ Soc. Sec. No.: _____

Date of Birth: _____ Age: _____ Sex: _____ Height: _____ Weight: _____
(Month) (Day) (Year)

2. Home Address: _____
(Number & Street) (City) (State) (Zip Code)

Home Phone No.: _____ Work Phone No.: _____
(Area Code)(Number) (Area Code)(Number)

Email Address: _____ Occupation: _____

Mailing or Billing Address (if other than Home Address): _____
(Street/Apt No.-P.O. Box) (City) (State) (Zip Code)

3. Dependents Coverage: I wish to apply for coverage for my following dependents:

First, Middle and Last Name	Date of Birth	Age	Sex	Ht	Wt	SSN	Relationship

4. Benefits Being Applied For: (check one) Option 1 Option 2 Option 3 Option 4

Daily Hospital Confinement Benefits per day.....	\$250	\$500	\$750	\$1,000
Daily Intensive Care/Coronary Care Unit Confinement Benefits.....	\$750	\$1,500	\$2,250	\$3,000
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

5. To qualify for coverage, you must answer the following questions:

a. Are you now, or within the past 24 months have you been: (a) confined to a hospital, nursing home or other medical institution; (b) receiving home health care services or kidney dialysis; or (c) medically diagnosed as having, or are you receiving or been advised by a doctor to seek, care and/or treatment for internal cancer, melanoma, Alzheimer's, systemic lupus, uncontrolled diabetes or high blood pressure, or congestive heart failure? Yes No

b. Have you been medically diagnosed as, or are you receiving or been advised by a doctor to seek care and/or treatment for being HIV-positive, or having AIDS or AIDS-related complex? Yes No

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

_____ (Attach additional signed & dated sheet if more room needed.)

6. Other Coverage:

a. 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.

b. 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: _____

PLEASE COMPLETE APPLICATION ON BACK SIDE

Application to WESTWARD LIFE INSURANCE COMPANY, Lakewood, CA

7. Insurance Premium \$ _____
 plus \$15.00 Administrative Fee
 Monthly Payment Mode:

Billing Method: Bank Draft Direct Bill List Bill (2 or more)]

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 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 may subject such person to criminal and civil penalties.

Dated at _____ this _____ day of _____, 20 _____

Signature of Applicant: **X** _____

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): _____

WLIC-HIP-03 APP

2

1203

GEM ADMINISTRATORS AUTHORIZATION TO HONOR CHECKS, SHARE DRAFTS, OR ACCOUNT DEBITS

 Name of Depositor as it appears on Banking Institution Records

_____ Account Number	_____ Routing/Transit Number	_____ Name of Banking Institution	_____ Branch
-------------------------	---------------------------------	--------------------------------------	-----------------

_____ Address	_____ City	_____ State	_____ Zip
------------------	---------------	----------------	--------------

As a convenience to me, I authorize you to pay and charge to my account checks, share drafts, electronic fund transfer debits or other account debits made upon my account by and payable to the order of the entity designated above or its legal representatives for membership, benefits and/or premiums. I agree that your treatment of each check, share draft or debit, and your rights with respect to it, will be the same as if it were signed or initiated personally by me. I further agree that if any check, share draft or debit is dishonored for any reason you will not be under any liability even though dishonor results in the forfeiture of benefits or membership. I further agree that this authorization is to remain in effect until you receive written notice from me of its revocation unless you end it earlier.

X _____

Signature of Depositor	Date	Additional Signature (If joint account)	Date
------------------------	------	---	------

Value Benefits of America Membership Enrollment Form Including Medical Savings Package

VBA Membership

Print Primary Member Name: _____
 (Last Name, First Name)

I agree to the terms and conditions as listed on the Value Benefits of America Membership brochure that I have received.

Signature of Primary Member: **X** _____ Date Signed: _____

Premium: Insurance Coverage	\$ _____
Administrative Fee	\$15.00
VBA Membership with Medical Savings Package*	\$10.00
VBA Enrollment Fee (One Time)	\$25.00
TOTAL PAYMENT DUE:	\$ _____
Please make check/money order payable to: GEM Administrators	

*Medical Savings Package for you and your family includes savings up to 50% or more at over 600,000 Affiliated Doctors & Clinics, Hospital Savings up to 50% or more, Dental Discounts Nationally, Chiropractic Discounts nationally to 50%, Alternative Medicine Savings of 25% and many other discounts on services and products.

Value Health Plan

SALES REPRESENTATIVE GUIDELINES

Effective Dates

Effective dates will be only on the 1st of each month.

Business must be received on or before the 1st of the month to become effective the 1st.

List Bill

We will **list bill with 2 or more applications**. You must submit first month's monies with all list bill cases. Please use the List Bill form with all list bills.

Supplies

All supplies must be obtained through your marketing director. If you do not have a marketing director, you may phone in, fax or email your supply order. All supply orders will be shipped via Mail or Ground.

Phone: 800-366-2467

Fax: 480-596-6518

Email: info@generalagentcenter.com

Monies Collected

Make checks payable to GEM Administrators. Applicant's can pay by Monthly Bank Draft or List Bill

Make sure all your clients know, Billing will occur approximately 15 days before due date.

Changes and Cancellations

Any changes including cancellation must be in writing and sent to GEM Administrators:

GEM Administrators

919 N. 1st St.

Phoenix, AZ 85004

Fulfillment

All fulfillment information will be mailed directly to your client for delivery.

Child Only Coverage

When applying for child only coverage you must charge the 19 year old adult rate for the oldest child and then charge the child rate for younger children in the same family. If you are writing one child only you must charge the 19 year old rate.

Complete the application with a parent listed as the Name of Member/Applicant. Write in after the parent name – Not To Be Covered. Complete all sections of application as normal.

See height & weight chart on reverse side

Height & Weight Chart

FEMALE		
<u>Height</u>	<u>Min. Weight</u>	<u>Max. Weight</u>
4'8"	77	212
4'9"	78	216
4'10"	79	220
4'11"	81	224
5'0"	83	229
5'1"	85	238
5'2"	87	243
5'3"	89	244
5'4"	91	250
5'5"	93	256
5'6"	96	262
5'7"	98	268
5'8"	101	274
5'9"	104	287
5'10"	107	288
5'11"	110	296
6'0"	114	305
6'1"	117	314
6'2"	120	323

MALE		
<u>Height</u>	<u>Min. Weight</u>	<u>Max. Weight</u>
5'0"	91	234
5'1"	93	237
5'2"	95	243
5'3"	98	247
5'4"	101	256
5'5"	103	262
5'6"	106	270
5'7"	109	276
5'8"	112	286
5'9"	115	296
5'10"	118	299
5'11"	121	308
6'0"	124	312
6'1"	127	323
6'2"	131	328
6'3"	134	339
6'4"	138	360
6'5"	142	385
6'6"	146	409
6'7"	150	418
6'8"	154	427