



Value Health Plan

**Sickness & Accident Hospital & Surgical Indemnity
Benefits for Individuals, Families and Groups**

PAYS IN ADDITION TO OTHER INSURANCE!

- **No Deductible or Co-Pays**
- **Use Any Hospital or Surgeon**
- **Benefits Paid Directly to You**

LIMITED MEDICAL BENEFITS SCHEDULE FOR A COVERED SICKNESS OR ACCIDENT

	Silver	Gold	Platinum
DAILY HOSPITAL BENEFITS			
Daily Hospital confinement from the 1st day up to 1 year per confinement	\$500	\$750	\$1000
Daily Intensive Care or Coronary Care from the 1st day up to 30 days per confinement	\$2000	\$3000	\$4000
SURGICAL BENEFITS			
Pays scheduled amount for surgery due to a covered sickness or injury up to a max of:	\$10,000	\$15,000	\$20,000
Pays scheduled expenses for administration of anesthesia during a covered surgery up to a max of:	\$2000	\$3000	\$4000
EMERGENCY BENEFITS			
Pays expenses incurred for emergency treatment due to a covered injury	\$125	\$187.50	\$250
Pays expenses incurred for ambulance services due to a covered injury	\$250	\$375	\$500

Your Coverage will remain in force as long as you are under age 75, you pay your premiums and are not in active military service and your policy is in force. Benefit amounts will be reduced 50% at age 65

AGE	Silver MONTHLY	Gold MONTHLY	Platinum MONTHLY
Child	\$20.00	\$30.00	\$40.00
18-39	\$40.00	\$60.00	\$80.00
40-49	\$50.00	\$75.00	\$100.00
50-59	\$75.00	\$112.50	\$150.00
60-64	\$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 the Group Accident and Health Insurance Policy No. G-610,090, Form No. G-19000. Coverage may vary or may not be available in all states. AG4886



AMERICAN GENERAL

Underwritten by The United States Life Insurance Company in the City of New York, a member company of American International Group, Inc.

With more than \$800 Billion in Assets, AIG is the world's largest and most successful insurance and financial services organization with more than 85 years of experience.

FOR VBA MEMBERS



Form VHP-4



Exclusions and Limitations

PRE-EXISTING CONDITIONS PROVISIONS FOR MEDICAL CARE BENEFITS

PRE-EXISTING CONDITION means:

- an injury or sickness which manifested itself within 12 months before a person became insured under a given benefit section of this policy in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment.
- an injury or sickness for which a person was recommended or received medical advice, diagnosis, care or treatment within 12 months before a person became insured under a given benefit section of this policy; or
- a pregnancy that exists on the date a person became insured under a given benefit section of this policy.

No charges incurred for a pre-existing condition will be considered covered charges under a benefit section until 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 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 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 and medical procedure, equipment, 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 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.

- would be given free of charge if the person was not covered. However, medical care benefits **will be paid** for covered
3. 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.

No benefits will be paid for any hospital confinement:

1. for treatment of psychiatric, mental, nervous or emotional disorders, alcoholism or drug addiction beyond the maximum period of benefits, per confinement, shown in the Schedule of Benefits.
2. due to the person's being intoxicated or under the influence of any drug, unless taken as prescribed by a physician; or
3. which begins after a person's insurance ends, regardless of when the injury or sickness occurred. However, hospital indemnity benefits may be provided as described in the Benefits After Insurance Ends provision.

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

MAIL APPLICATIONS TO:
Value Benefits of America
15575 N 79th Pl Suite 100
Scottsdale, AZ 85260
(800) 366-2467

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

Underwritten by 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 underwriting risks, financial obligations and support functions associated with the products issued by The United States Life Insurance Company in the City of New York are its responsibility. The United States Life Insurance Company in the City of New York is responsible for its own financial condition and contractual obligations.



VALUE HEALTH & VALUE HOSPITAL PLANS AGENT UNDERWRITING GUIDELINES

1. **ISSUE DATE:** If money is received with business by the 10th, the effective date will be the 15th and if it is received between the 11th and the 25th, it will be effective the 1st of the following month. If no money is received, we must receive the app by the 5th for an effective date of the 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 (for groups of 2 or more). Make sure the applicant is aware that their account will be drafted immediately if they did not submit money and will draft 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 pending receipt of the original.
4. **MUST INCLUDE THESE SIGNED FORMS: HIPAA Authorization, VBA Membership Enrollment, Consumer Form, Automatic Monthly Bank Draft (and voided check).**
5. **CONTACT INFORMATION:** Most correspondence regarding application is sent to the agent via email, phone or US Mail. We may be required to contact the applicant so always include the applicant's 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 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

VALUE HEALTH / VALUE HOSPITAL PLANS

Field Underwriting Guide for Medical Condition Acceptance or Rejection

1. Application only applies to the past 2 years
2. Applicant who has a condition that is degenerative in nature may not be accepted.
3. Applicant who has been advised to have hospitalization or surgery and has not done so will be rejected.
4. Unlisted conditions should be referred to underwriting.
5. To qualify for coverage, All Applicant's Pre-Existing Conditions must be controlled.

Disease or Condition	Std/Reject	Disease or Condition	Std/Reject
Addison's Disease	Reject	Carpal Tunnel Syndrome (over 1 year)	Std
Adenocarcinoma (treatment free 2 years)	Std	Cataract (operated)	Std
Adenoids (over 1 year)	Std	Cerebral Palsy	Reject
Adhesions	Std	Cerebro-vascular Disease or disorder	Reject
Alcoholism	Reject	Chronic Obstructive Lung Disease	Reject
Alzheimer's Disease	Reject	Cleft Palate, Harelip (operated 1 year)	Std
Amputation, due to trauma (over 2 years)	Std	Club Foot (unoperated)	Reject
Amputation, due to disease	Reject	Colitis, non-ulcerated & controlled (2 years)	Std
Amyotrophic Lateral Sclerosis	Reject	Colostomy	Reject
Anal Fissure or Fistula (corrected)	Std	Congestive Heart Failure (controlled 2 years)	Std
Anal Polyp or Rectal Polyp (corrected)	Std	Convulsions (within 2 years)	Reject
Anemia, Sickle Cell, Aplastic	Reject	Corneal Transplant or Ulcer (operated)	Std
Aneurysm (2 Years)	Std	Coronary Artery Disease (uncontrolled)	Reject
Angina Pectoris (2 Years)	Std	Crohn's Disease	Reject
Arteriosclerosis, Atherosclerosis (over 2 Years)	Std	Cushing's Disease or Syndrome	Reject
Arteriosclerotic Heart Disease (2 Years)	Std	Cystitis	Std
Arteriosclerosis Obliterans	Reject	Cystic Fibrosis, benign	Reject
Arthritis or Rheumatism (controlled)	Std	Deafness	Std
Arthritis, severe or crippling	Reject	Detached Retina (operated)	Std
Asthma, Allergies (not hospitalized)	Std	Diabetes (diet or pill controlled)	Std
Back Sprain, Strain (one time)	Std	Diabetes (insulin controlled)	Std
Bladder Stones - Urinary (corrected)	Std	Diabetic Neuropathy (uncontrolled)	Reject
Blood Pressure, high (controlled - not hospitalized)	Std	D & C (Dialation & Curettage)	Std
Blood Pressure, high (hospitalized)	Reject	Disc, Cervical, Dorsal, Lumbar or Sacroiliac (over 2 years)	Std
Brain Syndrome, chronic	Reject	Divericulitis, Diverticulosis (controlled 4 years)	Std
Brain Tumor	Reject	Down's Syndrome	Reject
Breast Implants	Std	Drug Abuse	Reject
Breast Tumor, benign (operated - over 2 years)	Std	Ear Disorder, Labyrinthitis, Otitis Media, Menieres Disease (full recovery)	Std
Bright's Disease or chronic Nephritis	Reject	Eczema	Std
Bronchitis, chronic	Reject	Edema	Std
Bronchitis (not hospitalized)	Std	Emphysema (no oxygen & not hospitalized controlled at least 2 years)	Std
Bunions	Std	Encephalitis	Std
Bypass of Intestines or stapling for weight control (over 2 years)	Std	Endometriosis or Endometritis (controlled)	Std
Cancer, Skin, not melanoma or invasive (1 year)	Std	Epilepsy, petit mal (no seizures 1 year)	Std
Cancer, other than skin (no treatment, 2 years)	Std	Epilepsy, grand mal	Reject
Carcinoma in situ (2 years)	Std		
Cardio-Renal Disease	Reject		

VALUE HEALTH / VALUE HOSPITAL PLANS (continued)

Disease or Condition	Std/Reject	Disease or Condition	Std/Reject
Esophagus Stricture or Esophagitis	Std	Myasthenia Gravis	Reject
Female Disorders (corrected)	Std	Narcolepsy (controlled)	Std
Fibrocystic Breast Disease or Mastitis (controlled 1 year)	Std	Nasal Polyps (corrected)	Std
Fibroid Tumor (operated 1 year)	Std	Nephritis or Nephrosis (controlled 2 years)	Std
Fractures (no pins or plates)	Std	Nervous Mental Disorders, if hospitalized, institutionalized or disabled in last 2 years)	Reject
Fractures (requiring pins, plates, wires, nail or screw - 1 year)	Std	Orchitis	Std
Gall Bladder Disease, Gallstones (operated)	Std	Organ Transplant (other than cornea)	Reject
Gastrectomy (1 year)	Std	Osteoarthritis (controlled 2 years)	Std
Genito-urinary disorders (corrected)	Std	Osteomyelitis (controlled 2 years)	Std
Glaucoma (operated)	Std	Osteoporosis (controlled 2 years)	Std
Goiter (operated)	Std	Paget's Disease	Reject
Gout, Gouty Arthritis (controlled)	Std	Pancreatitis - single episode (1 year)	Std
Headaches, migraine	Std	Pancreatitis - multiple episodes	Reject
Heart Attack, disease or disorder (over 2 years)	Std	Paraplegia	Reject
Heart Pacemaker	Reject	Parkinson's Disease	Reject
Heart Surgery (full recovery - over 2 years)	Std	Peptic Ulcer (operated)	Std
Hemangioma	Std	Peritonitis (controlled)	Std
Hemophilia	Reject	Pernicious Anemia (controlled 1 year)	Std
Hemorrhoids (operated)	Std	Pneumonia (1 time)	Std
Hepatitis (Types A & B - no complications 2 years)	Std	Polyp (operated)	Std
Hepatitis (Type C)	Reject	Pregnancy	Reject
Hernia (operated)	Std	Prostate disorder, benign (corrected)	Std
Hip Replacement (over 1 year)	Std	Psoriasis	Std
Hodgkin's Disease (no treatment 2 years)	Std	Pulmonary Fibrosis (controlled 2 years)	Std
Huntington's Chorea	Reject	Quadriplegia	Reject
Hydrocephalus	Reject	Raynaud's Disease/Phenomena	Reject
Hydronephrosis	Reject	Rectal Abscess (corrected 1 year)	Std
Hyperglycemia (controlled 2 years)	Std	Sciatica (controlled 1 year)	Std
Hypoglycemia (controlled 2 years)	Std	Scoliosis (controlled 1 year)	Std
Intestinal Obstruction (corrected)	Std	Septum, Deviated (corrected)	Std
Kidney Failure	Reject	Shingles (controlled 1 year)	Std
Kidney Infection acute (corrected 1 year)	Std	Sinusitis, chronic (controlled)	Std
Kidney Removal (within 2 years)	Reject	Spina Bifida	Reject
Kidney Stones or Colic (corrected)	Std	Spine, degenerative disease	Reject
Knee Replacement (1 year)	Std	Stasis Ulcer (operated)	Std
Leukemia (if treated in past 2 years)	Reject	Stroke (controlled over 2 years)	Std
Liver Disease, enlarged, cirrhosis	Reject	Tendinitis (corrected)	Std
Lung Disease - silicosis, anthracosis (1 year)	Reject	Thrombosis (controlled 2 years)	Std
Lupus, disseminated - systemic	Reject	Thyroid Disease (controlled)	Std
Lupus, discoid (within 2 years)	Reject	Tonsillitis	Std
Mastectomy, benign (1 year)	Std	Tumor, non-malignant (operated)	Std
Mastitis, cystic, benign (1 year)	Std	Ulcer, stomach, peptic and/or duodenal (operated)	Std
Meningitis (over 2 years)	Std	Ulcerative Colitis	Reject
Menopause Syndrome (over 2 years)	Std	Urinary Tract disorders (controlled)	Std
Mental Retardation	Reject	Valve Replacement (Heart)	Reject
Mononucleosis (recovered)	Std	Varicose Veins, Varicose Ulcer or phlebitis (operated)	Std
Multiple Sclerosis	Reject	Wheelchair or walker required for movement	Reject
Muscular Dystrophy	Reject		



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:

Table with 8 columns: First, Middle and Last Name, Date of Birth, Age, Sex, Ht, Wt, Social Security No., Relationship

BENEFITS BEING APPLIED FOR:

Table with 4 columns: Benefit type, Silver, Gold, Platinum. Includes Daily Hospital Confinement Benefits, Daily Intensive Care/Coronary Care Unit Confinement Benefits, Maximum Emergency Accident Treatment Benefits, Maximum Ambulance Transportation Benefits, Maximum Surgical Benefits Per Schedule.

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, high blood pressure, albumin or sugar in the urine, diabetes, cancer, tumors or ulcers?
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?
3. Please give details to any "Yes" answers, specifying person, condition, dates, treatment received and/or recommended and current status:

OTHER COVERAGE:

- 1. Are you now covered under, or awaiting issuance of, any accident or health insurance?
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?

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) _____

REQUIRED FOR NEW VALUE HEALTH & VALUE HOSPITAL APPS

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

Value Health Consumer Form

Each applicant who purchases the Value Health Plan 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

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 _____ State _____ 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 \$ _____ =	\$	\$	NA
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: ****	\$	\$	\$

(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 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 and 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 PLACE, SUITE 100
SCOTTSDALE, AZ 85260

Marketed By:

GAC #: