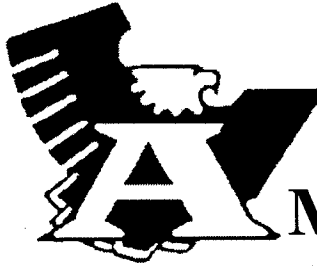


**PROTECT YOU AND YOUR FAMILY WITH  
AMERICAN SENTINEL INSURANCE COMPANY'S  
AFFORDABLE HEALTH INSURANCE PLAN**

**ILLINOIS**



**AMERICAN SENTINEL  
INSURANCE COMPANY**

**American Sentinel Insurance Company  
Sickness & Accident Plan**

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**READ INSIDE THIS BROCHURE ABOUT THIS VALUABLE HEALTH  
INSURANCE PLAN FOR YOU AND YOUR ELIGIBLE DEPENDENTS**

**Am I eligible?** If you are an hourly employee or independent contractor you may purchase this plan to cover you, your spouse and your eligible dependent children.

**When can I enroll?** You may enroll yourself and your eligible dependents within 31 days once you become eligible, or during an open enrollment period. You need not wait for an open enrollment period if you have a qualified life status change.

**When will my coverage begin?** Your coverage will begin on the first day of the month after you enroll.

**Questions?** Call 1-800-692-7338

**PLEASE NOTE:**

**THIS IS NOT A MEDICARE SUPPLEMENT POLICY AND COVERAGE  
UNDER THIS POLICY IS NOT CREDITABLE TO MEDICARE.**

**WHAT HAPPENS NEXT:** Once your premium has been received, you will receive a Certificate, ID Cards, claim forms and prescription drug cards.

**WHEN DOES MY COVERAGE TERMINATE:**

- The date you are no longer eligible unless contributions for coverage were made in advance in which case coverage will terminate at the end of the period for which premiums have been paid; or
- Any premium due date, if full payment for coverage has not been made within 31 days following the premium due date; or
- The date the policy terminates; or
- The date a covered person enters an armed service on full-time active duty. Premium shall be returned on a pro-rata basis if we are notified in writing; or
- The date you become eligible for an employer sponsored group medical program, other than this plan, regardless of whether or not you participate in the plan.

**EXCLUSIONS:**

- Intentionally self-inflicted injuries, suicide or any attempt thereat while sane or insane;
- Declared or undeclared war or any act thereof;
- Serving on full-time active duty in the armed forces of any country or international authority;
- Commission of a felony;
- Flying as a pilot or crew member of any aircraft or travel or flight, including boarding or alighting, in any vehicle or device while being used for any test or experimental purpose or while being operated by, for or under the direction of any military authority other than the Military Airlift Command (MAC) of the United States or similar law;
- Work-related injury or sickness, whether or not benefits are payable under Workers Compensation or similar law;
- With respect to Accidental Death benefits, sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, except infections which result from an Accidental Injury or infections which result from accidental, involuntary or an unintentional ingestion of a contaminated substance;
- Eye examinations for glasses; any kind of eye glasses, or prescriptions thereof;
- Normal health check ups, ear examinations, or hearing aids unless provided for under the policy;
- Treatment in a hospital or facility owned or run by the United States Government, unless a charge is made for such services in the absence of insurance; or in a hospital which does not unconditionally require payment;
- Dental care or treatment other than care of sound, natural teeth and gums required on account of injury resulting from an accident while the insured is covered under the policy, and is rendered within 6 months of the accident;
- Cosmetic surgery, except surgery, which the covered person needs as the result of an Accident, which happens while covered under the policy. The surgery must be performed within 90 days of the Accident causing the injury and while such person's coverage is in force;
- Expenses used to meet the deductible, or in excess of the co-insurance level, or in excess of those expenses considered usual and customary;
- Services provided by a member of the covered person's immediate family or services provided by the policyholder;
- Driving a motor vehicle while intoxicated;
- Voluntary self administration of any drug or chemical substance not prescribed by, or taken according to the directions of a Doctor;
- Expenses incurred to the extent that they are paid or payable under any automobile insurance policy without regard to fault. (does not apply in any state where prohibited);
- Treatment of the feet (including, but not limited to corns, calluses, bunions or toenails) for other than Accidental Injury;
- Elective sterilization or its reversal;
- Vasectomy;
- Services in excess of 12 visits per contract year for physiotherapy, including spinal manipulations;
- Weight loss treatment;
- Treatment of obesity, except for surgical treatment of morbid obesity when the insured persons weight is at least twice the ideal weight specified for frame, age, height and sex;
- Care and treatment of acne;
- Circumcision;
- Correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related services;
- Oral surgery except for surgical extraction of full bony impacted wisdom teeth.
- **PRE-EXISTING CONDITIONS:**

We will not pay benefits for a condition for which a covered person receives medical treatment or advice within 6 months before being covered under the policy. This does not apply if:

- The covered person has received no such treatment, care or advice for that condition for 6 straight months after being covered under the policy; or
- The covered person has been covered under the policy for 12 months.
- Pre-existing condition limitations do not apply to newborn or adopted children or to any pregnancy.

Any pre-existing condition limitation can be reduced by the period of time you were previously insured for the condition, provided you were validly insured under a prior plan, and became insured under this plan within 63 days of termination of your prior plan.

This brochure is a brief summary of the plan; the insurance certificate is the official document governing the provisions of this plan.

Underwritten & Administered by:

American Sentinel Insurance Company  
P.O. Box 61140  
Harrisburg, PA 17106-1140

**ENROLLMENT FORM***Please Print or Type All Answers*

Applicant's Full Name: Last First MI			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated		<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Applicant's Home Address		Street		City		County		State Zip Code	
Social Security Number				Date of Birth		Home Phone Number Area Code (     )			
Employer			Date of Hire _____ Effective Date _____		Daytime Phone Number Area Code (     )				
Address					Group Number				
City		County		State		Zip Code			
Beneficiary					Relationship to you				

**IF DEPENDENT COVERAGE IS REQUESTED, LIST ALL ELIGIBLE DEPENDENTS**

Full name (last, first, middle initial)	Date of Birth (MM/DD/YY)	Age	Male Female	Social Security Number	If a dependent child is 19 but less than 25 years of age, is he or she a full-time college student or disabled?
Spouse (full name)			<input type="checkbox"/> Male <input type="checkbox"/> Female		
Child (full name)			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Full-time Student <input type="checkbox"/> Disabled
Child (full name)			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Full-time Student <input type="checkbox"/> Disabled
Child (full name)			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Full-time Student <input type="checkbox"/> Disabled

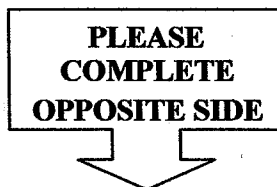
The coverage for which you are applying includes a Pre-existing limitation which states: We will not pay for a condition for which you, your spouse or covered dependent has received medical treatment, care or advice within 6 months before being covered under this policy. This Pre-existing limitation does not apply if:

- you, your spouse or covered dependent has received no such treatments, care or advice for that condition for 6 straight months after being covered; or
- coverage has been in effect for 12 months; or
- the condition is a pregnancy.

This Pre-existing limitation can be reduced by the period of time you, your spouse or dependents were previously insured under a prior plan, if coverage under this plan is effective within 63 days of termination of your prior plan.

I hereby apply for coverage indicated. I understand this application is subject to approval by American Sentinel Insurance Company and/or its reinsurers, and any coverage provided is also subject to the terms of agreement and/or contracts issued to me. Any persons or organizations, or any government agency having provided health care services to me, or any person named on this application or attachments to this application, either prior to or during the period of the contract, is authorized to furnish to American Sentinel Insurance Company, any information or records related to any claims submitted. "Any person 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 act, which is a crime and subject to criminal and civil penalties." I verify that statements made in this application are true and correct.

Date Signed \_\_\_\_\_ Signature \_\_\_\_\_



Were you or any of your dependents ever treated or advised that you have any of the following conditions:

- Myocardial Infarction (Heart Attack) Congestive Heart Failure or Chronic Obstructive Pulmonary Disease
- Cerebral Vascular Accident (Stroke) or any conditions of the circulatory system
- Asthma, Emphysema, or any conditions of the respiratory system
- Allergies
- Diabetes
- High Blood Pressure
- Hepatitis
- Acquired Immune Deficiency Syndrome
- Migraine Headaches
- Any conditions for which you or your dependents were treated within the last six months.

Name of person and condition \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Answers to these questions will not be used to deny coverage for you or any of your dependents.

**PLEASE RETURN  
APPLICATION TO  
YOUR GROUP  
ADMINISTRATOR**