[redacted]

[redacted] IN [redacted]

February 1, 2007

RECEIVED
FEB 28 2007

[redacted]
Anthem Blue Cross and Blue Shield
12464 La Grange Road
PMB 134
Louisville, KY 40245-1901

0
9
/
2
4
/
2
0
0
7

Dear Ms. [redacted]:

I am responding to your letter dated January 25, 2007 and in reference to my ID# [redacted]

In reviewing the question of my height and build in the original application, there was clearly a typo in the original application. My thought is perhaps my agent mistyped my written application as he took care of filling out the on-line application for me.

My height and build is (and was at the time of my application) height: 5'10"; and weight: 275 pounds. I hope this provides the needed clarification.

Sincerely,

[redacted]

[redacted]

11010

Individual Misrep Claims >= $2,500.00 or Drugs >= $500.00
or Abuse Charges for Drugs >= $500.00 in a 30-Day Window

08/14/20

Subsc-Mbr ID / Claim ID / Svc Date	Subsc-Mbr Name	Prod ID	Group ID	Orig Eff Date	Charged
[redacted]	(MI) h/o broken leg with rod insert.	APSI0227	00060020	05/01/2006	$7,405.34
(1) [redacted]		APSI0227	00060020	05/01/2006	$7,405.34
Misrepresentation Claims				Voice Sig 4/21	$7,405.34
[redacted]					$7,405.34
	Code / Description				$7,405.34
05/[redacted]/2006	04109 OTHER STREPTOCOCCUS				$7,405.34
05/[redacted]/2006	27800 OBESITY NOS				$0.00

09/24/2007

1/5/07 All claims are ITS from CT + MA with 5/[redacted]/06 → 5/[redacted]/06 dates

[redacted] Medical Center - CT — Reg recs rec'd 1-18-07
[redacted] - CT
Surgical [redacted] - MA
Cardiology [redacted] - CT
[redacted] Health Services - CT
[redacted] - KY - Reg recs

1/18/07 Records for [redacted] not requested. Weight on records from Meditate Medical Center show weight as 310 lbs 2 wks after signature date (+95 lbs).

1/19/07 Send SV per SE recs to CJO - MLM
Also req recs from Haney at some time. - MLM
Address changed on facets - MLM

2/6/07 - Sent no pay letter to the Best corporation CJO
2/15/07 - To Srvs for final decision. - MLM
2/21/07 - Per Hlw Consultant rescind. To CJO for committee prep. - MLM
2/28/07 Rescind per Committee - MLM
3/9/07 spoke to asst - (He forgot to call me back last week) - no written app - he took information over the phone. He is supposed to send me an email stating this - CJO

39

11084

Anthem Blue Cross and Blue Shield
P.O. Box 37810
Louisville, KY 40233-7810

Anthem.

[redacted]

09/24/2007

March 15, 2007

CERTIFIED MAIL [redacted]

[redacted] IN [redacted]

COPY

ID#: [redacted]

Dear Mr. [redacted]

As stated in our letter of January 25, 2007 it has come to our attention that your application for the Blue Access policy, offered by Anthem Insurance Company, contains incorrect and/or incomplete medical information.

The application you completed asks the following question(s):

Section D- your build

The above question was answered incorrectly on your application. Had we known of your true build, coverage would have been declined.

Therefore, your coverage is rescinded. We intend to recover full payments made on claims submitted. All claims that are currently pending will be denied. Any premium fees paid will be refunded within approximately 30 business days, minus any amount that is applied toward claim payments that have been made for this member.

Please be advised that you will not receive a Certificate of Creditable Coverage since your policy has been rescinded.

You have the right to appeal this decision. To initiate the appeals process, please forward your request for an appeal along with any additional information to the following address: Anthem Blue Cross Blue Shield, Appeals Department, P. O. Box 33200, Louisville, KY, 40232-3200. If you prefer, you may fax your appeal to [redacted].

Thank you for your attention to this matter. Should you have any questions, please call me at [redacted].

Sincerely,

[redacted]

Anthem Blue Cross and Blue Shield

Confidential notice: This message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited.

09/24/2007

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

[redacted]

IN [redacted]

COMPLETE THIS SECTION ON DELIVERY

A. [redacted] ☐ Agent ☐ Addressee

B. Received by (Printed Name) [redacted] C. Date of Delivery 3-23-07

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

RECEIVED MAR 26 2007

3. Service Type
☐ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) [redacted]

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

[redacted]

U.S. Postal Service
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)
For delivery information visit our website at www.usps.com

OFFICIAL USE

Postage $
Certified Fee
Return Receipt Fee (Endorsement Required)
Restricted Delivery Fee (Endorsement Required)
Total Postage & Fees $

Sent To
Street, Apt. No.; or PO Box No.
City, State, ZIP+4

Postmark Here

PS Form 3800, June 2002 See Reverse for Instructions

11009

WLP0007524
247M59798

[redacted]

From: [redacted]
Sent: Wednesday, April 25, 2007 12:14 PM
To: [redacted]
Subject: RE: Speak now ltr

[redacted],

As discussed in the ARC today, this member will remain rescinded.

Thanks,

[redacted] fax

From: [redacted]
Sent: Tuesday, April 24, 2007 10:51 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Speak now ltr

[redacted] please pull the file and reverse any decisions that may have been made on this account.

Thanks

[redacted]
Underwriting Manager
[redacted]
KY0302-A625

From: [redacted]
Sent: Tuesday, April 24, 2007 6:05 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Speak now ltr

If the agent did not send the app then we can't rescind. I need the get the agent's name so he can be contacted. His actions are not acceptable!

From: [redacted]
Sent: Monday, April 23, 2007 7:12 AM
To: [redacted]
Subject: RE: Speak now ltr

broker

[redacted]
Underwriting Manager
[redacted]
KY0302-A625

04/25/2007 10998

09/[redacted]/2007

WLP0007525

From: [redacted]
Sent: Friday, April 20, 2007 5:29 PM
To: [redacted]
Subject: RE: Speak now ltr

Captive or broker?

From: [redacted]
Sent: Friday, April 20, 2007 2:08 PM
To: [redacted]
Subject: RE: Speak now ltr

Yes you are correct

[redacted]
Underwriting Manager
[redacted]
KY0302-A625

From: [redacted]
Sent: Thursday, April 19, 2007 4:12 PM
To: [redacted]
Subject: RE: Speak now ltr

So he submitted electronically with VS and never sent a copy of the application to the applicant to review? Am I understanding this correctly?

From: [redacted]
Sent: Friday, April 06, 2007 9:06 AM
To: [redacted]
Subject: FW: Speak now ltr

See below for further update

[redacted]
Underwriting Manager
[redacted]
KY0302-A625

From: [redacted]
Sent: Friday, April 06, 2007 9:03 AM
To: [redacted]
Subject: RE: Speak now ltr

There is a note in the file dated 3/[redacted]/07 by [redacted] that says "Per [redacted] build is rescind either way- rescind per committee." The rescission was completed on 3/[redacted]/07, so should I still contact the agent? In my notes, I have that he said he since he took the application over the phone, he did not send anything to the member. I will try to get him to send me that in writing. I am sending him an email, I will copy you on it.

[redacted]

From: [redacted]
Sent: Friday, April 06, 2007 8:58 AM

To: [redacted]
Cc: [redacted]
Subject: RE: Speak now ltr

Yes, and we need to know if he mailed a copy of the application to the applicant with the letter stating if anything is incorrect to let us know.

[redacted]
Underwriting Manager
[redacted]
KY0302-A625

From: [redacted]
Sent: Friday, April 06, 2007 8:33 AM
To: [redacted]
Subject: RE: Speak now ltr

The agent never sent me anything. When I contacted him and finally spoke to him, he stated he did not have a paper application, that this was taken over the phone. I asked him to send me an email stating that and have never received it. I had to call him several times to even speak with him about this. Should I try again?

From: [redacted]
Sent: Friday, April 06, 2007 8:10 AM
To: [redacted]
Subject: FW: Speak now ltr

See below. Can someone get me an update?

[redacted]
Underwriting Manager
[redacted]
KY0302-A625

From: [redacted]
Sent: Thursday, April 05, 2007 7:00 PM
To: [redacted]
Subject: RE: Speak now ltr

What happened with this one?

[redacted]
Associate General Counsel
Mail Point: KY0301-A605
Tel: [redacted]
Fax: [redacted]

From: [redacted]
Sent: Thursday, March 01, 2007 1:24 PM

To: [redacted]
Cc: [redacted]
Subject: RE: Speak now ltr

I thought if the agent received a paper application they had to send us the paper application because we had to audit the paper against what was keyed. We need to go back to the agent and see if they have the paper application because we only have the on-line on Ultera.

[redacted]
Underwriting Manager
[redacted]
KY0302-A625

From: [redacted]
Sent: Thursday, March 01, 2007 1:08 PM
To: [redacted]
Cc: [redacted]
Subject: Speak now ltr

Sarah,

In yesterday's committee meeting, a file was reviewed on [redacted] whose weight was put on the application as 215lbs on 4/[redacted]/06 and we have records stating his weight on 5/[redacted]/06 was 310lbs. His reply to the speak now letter came in yesterday afternoon and he thinks that the agent may have mis-keyed his weight off the original written application. The amber states his build at the time of the application was 5'10" 275 lbs. It was decided yesterday to rescind this member due to build. My question is, should we still rescind him based on the information in the speak now letter?

Thanks,

[redacted]
Individual Underwriting
[redacted]

09/[redacted]/2007

UNICARE.

ISG Operations
220 Remington Blvd.
Bolingbrook, IL 60440
Fax: 1-630-679-4519

April [redacted], 2007

[redacted]
[redacted] TX 758[redacted]

Regarding: [redacted]
ID Number:
Group Number:
Policy Effective Date: December [redacted], 2005
UniCare Agent: [redacted]

Dear [redacted]

In reviewing the claims from East Texas Radiological Consultants for services rendered December [redacted], 2005, we find there were material misrepresentations and omissions on your Application for UniCare Individual Enrollment signed November [redacted] 2005. A copy of this application is enclosed for your review.

The application you completed disclosed the following medical history for yourself:

- Height 5 feet 4 inches and weight 160 pounds.

Based upon this history, you became enrolled effective December [redacted] 2005. Subsequently, during a medical investigation, UNICARE requested and received medical records from Central Texas Digestive. Review of these records disclosed the following significant medical history for you:

- 10-[redacted]2005 This patient follows-up in clinic with recurrent and intermittent episodes of nausea. There was considers that this was probably related to medications and all medicines were discontinued without improvement, so she resumed her Avandia, Nexium, and Teveten. Past Medical History: Notable for diabetes and hypertension.

Had this information been disclosed in the UniCare Individual Application Health History, Section 6 pages 3 and 4, our medical underwriting guidelines would have prohibited us from offering the enrollment as requested.

Your contract with us, consisting of the policy and the application, provides that we may rescind the policy if material health information is omitted from the application or misstated. Specifically authority for this action can be found under the Conditions of Application, Section 7, item #10, which states,

"I have personally read and completed this application. Nothing has been left off regarding the past or present health of anyone listed on this application. I understand that no one listed on this application is eligible for benefits if any information on this application is false, incomplete or omitted. UniCare may void all coverage from the original effective date of the agreement for such material misstatements or omissions."

In addition, Section 1, paragraph 6 of your UniCare Individual Policy states,

"IF WITHIN TWO YEARS AFTER THE EFFECTIVE DATE OF THIS PLAN, WE DISCOVER ANY MATERIAL FACTS THAT WERE OMITTED OR THAT YOU OR YOUR INSURED FAMILY MEMBERS KNEW, BUT DID NOT DISCLOSE IN YOUR APPLICATION, WE MAY RESCIND THIS PLAN AS OF THE ORIGINAL EFFECTIVE DATE."

Because the medical history omitted from your application would have precluded us from issuing the policy as applied for, your current UniCare Policy will be retroactively canceled to the original effective date. All suspended claims will be denied. All claims paid in error will be adjusted. A check representing a full refund of all premium submitted, less the amount of any claims paid by UniCare will be processed and sent to you under separate cover within thirty (30) working days of the date you receive this letter.

Should you feel the information upon which our decision was based is erroneous or if you have any questions regarding UniCare's decision to rescind your policy, please submit your written concerns and all supporting documentation to my attention at the address noted above.

Sincerely,

[redacted]
Underwriting Services
UniCare Life and Health Insurance Company

Committee Review Date: 3/22/07 State: Texas 90 Day Date: 4/15/07	UNICARE.	Committee Decision Rescind ☐ No Retroaction ☐ Retro Waiver ☐ Retro Rate Up ☐

Member Name: [redacted]

HCID Number: [redacted] **MC Number:** [redacted]

Application Signature Date: 11[redacted]05 **Effective Date of the Policy:** 12[redacted]05 **Plan:** [redacted]

Membership Information: Active **Referral Source:** Claims **Date of Referral:** 7/26/06

Date claim received that was sent for review: 7[redacted]06 **Diagnoses on Claim:** Lump or Mass in Breast

Medication Listed on Intelliscript: Levaquin, Advair, Albuterol, Prednisone, Zithromax, Norvasc, Alprazolam, Prepac, Cipro, Diazepam, Promethazine, Phenazopyriding, Transderm Scopolamine, Visicol, Metformin
Medication Listed on Reviewpoint: Prochlorperazine

Application/Health Statement:
- Height 5 feet 4 inches and weight 160 pounds

Underwriting History:
Approved Preferred

Relevant Medical History Prior to Effective Date:
Provider: Central Texas Digestive
- 10[redacted]2005 This patient follows-up in clinic with recurrent and intermittent episodes of nausea. There was considers that this was probably related to medications and all medicines were discontinued without improvement, so she resumed her Avandia, Nexium, and Teveten. Past Medical History: Notable for diabetes and hypertension

Relevant History Post Effective Date:
Medical records/information received from [redacted] indicate the following history:
- "I specifically asked the agent who signed me up for your insurance policy how to check the boxes of health questions, he stated if you are not on medication for any of the problems to check "NO." In 2005 I was not on medication for blood sugar or hypertension. I also check my blood sugar once or twice a month to make sure mine was not out of the normal range. Diet, exercise and awareness was controlling my blood sugar and blood pressure with out taking medication for either of these. I have never had nor has it been ordered to take a Glucose Tolerance Test which is the specific test needed for diabetics. In 2005 I also monitor my blood pressure checks. Diet and exercise was all that was needed to keep it in the normal range."

Medical Underwriting Guidelines:
- Diabetes and hypertension would have been decline per Complications Requiring Declination per MUG 250
- Recommend no retroaction. Unable to prove intent of member. No response from agent to verify if this information was told to her.

Other Medical History:
None

Health Questions Answered "NO" should be Yes:
Sect 6 questions 3 and 13

Reviewing Underwriter:
[redacted]

I was diagnosed with non-Hodgekins Lymphoma in September 13, 2004. I have been covered by an individual policy with Fortis Insurance policy # 00505534 80-m since august 7, 2003.

I have been through chemo therapy and am being prepared for a stem cell transplant within 3-4 weeks. Dr Stiff at Loyola medical Center in Maywood is my doctor for the procedure. I was called on the phone on April 18, 2005 and told that my insurance company was cancelling my coverage. I never received any written notification of this.

I called them and they faxed me the attached letter. (exhibit #1) I am being accused of falsely stating my health history. I fully disclosed my history to them, I have no Knowledge of having gall stones or any blood clots. I disclosed Kidney stones to them. I have not sought any treatments or medication ever for gall stones or blood clots.

I must have the stem cell ~~transplant~~. It is a matter of extreme urgency that I receive my transplant in 3 weeks. I have had all the preliminary Chemo and I am ready.

This is an urgent matter! Please help me so I can have my transplant as scheduled. Any delay could threaten my life.

I give you permission to discuss this matter with my sister, Peggy M. Raddatz. [redacted]

[redacted] Raddatz 4-21-05

04/26/2005 11:42 PAGE 09

April 15, 2005

FORTIS

Solid partners, flexible solutions®

Mr Otto Raddatz
[redacted]
[redacted] IL [redacted]

Re: Policy / Certificate Number [redacted]

Dear Mr Raddatz:

Through a series of medical questions on your July 8, 2003 application / enrollment form, we asked that your family's health history be completely and accurately disclosed for the purpose of determining insurability.

During the course of our consideration of your claim for benefits, we received information regarding Otto Raddatz's health history, which was reported to us by Dupage Medical Group. The information we received pertained to one or more medical conditions that were not disclosed on the application / enrollment form including, without limitation the following: abnormal abdominal CT scan showing atherosclerotic abdominal aorta with infrarenal aneurysm and cholelisthiasis (gall stones). Specifically, we have discovered medical records dated from February 9, 2000 to March 13, 2000 that revealed this health history.

Unfortunately, this history came to our attention after a claim was submitted. Under the circumstances, we must reform coverage. Had our Underwriting Department been aware of this medical history at the time of application / enrollment form was approved, eligibility for insurance coverage would have bee affected. Therefore, we will be removing Otto Raddatz from coverage based on the material misrepresentation with respect to one or more questions on the application / enrollment form, including without limitation the following: 18b 18c 24. Please refer to the copy of the application / enrollment form included with your policy / certificate.

We are enclosing an Amendment of Application that excludes coverage for Otto Raddatz from the effective date of the coverage. If you choose to accept the above Amendment of Application, please sign, date and return it to Fortis. The policy/certificate will remain in force for all other previously covered family members. If you choose not to accept and sign the Amendment of Application, you will leave us no alternative except to rescind the entire policy back to the effective date of August 7, 2004. In either outcome, Fortis will arrange for any appropriate refund of premium.

Fortis Health

501 West Michigan
P.O. Box 3050
Milwaukee, WI
53201-3050
Telephone
1 800 800 1212

We require receipt of the signed Amendment of Application within 30 calendar days from the date of this letter. The signed Amendment of Application should be faxed to my attention at 1-414-299-1266.

If you have any **new information** that may impact this decision, please submit this information in writing. However, if the amendment of application is not received within the specified time frame, we will proceed with the rescission of coverage regardless of the receipt of appeal information.

The above information was reviewed in accordance with Fortis Insurance Company's underwriting guidelines, practices and procedures. All of the Company's rights and defenses, whether or not specifically mentioned herein, are reserved.

Yours sincerely,

[redacted]

Senior Individual Medical Underwriter
1-800-800-1212 Extension [redacted]
Facsimile: 1-414-299-1266

[redacted]

Enclosures

OFFICE OF THE ATTORNEY GENERAL
STATE OF ILLINOIS

Lisa Madigan
ATTORNEY GENERAL

May 3, 2005

[redacted]
Fortis Health
501 West Michigan
P. O. Box 3050
Milwaukee, WI 53201-3050

Peggy Raddatz
RE: Otto Raddatz
[redacted]
[redacted] IL [redacted]

Dea[redacted]g,

We are in receipt of your formal response dated April 29, 2005 regarding Mr. Otto Raddatz. I have also had discussion with an attorney for Assurant Health named [redacted]. According to Ms. Quoartaro, Mr. Raddatz's insurance is being res[redacted] based on the fact that he did not state on his application of July 8, 2003 the presence of an aortic aneurysm. After reviewing the records again and speaking to the doctor caring for Mr. Raddatz at the time the CT scan was done, it is clear that Mr. Raddatz had no knowledge of the aneurysm, which was found incidentally on a CT scan done in February of 2000 by Mr. Raddatz's physician, Dr. [redacted].

I[redacted]cl's medical notes at no time state that Mr. Raddatz was informed of an aortic aneurysm or indicate that Mr. Raddatz was in need of follow-up care related to an aneurysm. Notations made by D[redacted]l on the CT report of February 11, 2000 state: "Have kidney stones come in tomorrow". D[redacted]l, who is now retired from practice, informed me that he does not recall telling Mr. Raddatz of the aneurysm. The fact that it is not written in the medical records that further attention related to an aneurysm is needed is further evidence suggesting Mr. Raddatz was not told he had an aneurysm.

Our office believes that it is highly likely that Mr. Raddatz was not informed of his aortic aneurysm until he received notification from Fortis that his policy was being terminated. Mr. Raddatz saw a physician, I[redacted]a, who had replaced D[redacted]cl, for the first time in four years in August 2004. As reflected in the notes of that visit, neither he nor the physician mentioned an aneurysm. Next, when he saw a hematologist, D[redacted]on, after the CT scan of September 2004, Mr. Raddatz does not indicate in his initial history the presence of an aneurysm nor does I[redacted]n mention an aneurysm in his report to [redacted]ra. Again, this would again indicate that Mr. Raddatz was not told of an aortic aneurysm.

Furthermore, the fact that Mr. Raddatz never sought medical attention after his visits of February and March 2000, until he became symptomatic from his current illness, can be viewed

as further evidence suggesting Mr. Raddatz did not make any fraudulent statements or material misrepresentations on his enrollment form. As stated several times on the complaint forms filed with our office, Mr. Raddatz was unaware of the presence of the aneurysm. Clearly, he did not know that he had an aneurysm until recently, when his policy with Fortis insurance was terminated as the result of post-medical underwriting following chemotherapy treatment.

During this recent underwriting process, Fortis asserts that questions 18b, 18c, and 24 on the enrollment for were answered incorrectly. However, each of these questions is ambiguous, and they do not sufficiently elicit the level of detail you are purportedly seeking. These are also the kind of questions that are difficult for a lay person to answer, particularly with the degree of specificity and completeness that you are now saying was required of Mr. Raddatz. Indeed, Mr. Raddatz was clearly making no effort to withhold the fact that he had undergone a CT scan since he disclosed the fact that he had seen a Dr[redacted] for kidney stones. Therefore, if the application is read as a whole, the information known to Mr. Raddatz was provided on his application.

We are stating that Mr. Raddatz's health insurance policy should not have been rescinded. Mr. Raddatz has been undergoing treatment under the reasonable assumption that he has medical coverage. He suddenly faces not only life-threatening illness but now the inability to afford the only treatment that may help him. The timing of rescinding Mr. Raddatz's insurance is such that he cannot possibly make other arrangements for coverage before it is too late. Clearly, Mr. Raddatz will die very soon without receiving the medical care that he needs. Our office is making every effort to assist this consumer, and we believe we have satisfied the guidelines as set forth by his policy by providing the above-mentioned information. In addition, we agree that each insured must be treated equally and fairly according to the guidelines set forth by their health insurance policy. However, many situations are not clear and in these situations, in the interest of human fairness, decisions should be made to best protect the consumer.

We greatly appreciate your continued review of this matter. We hope you will agree that we have adequately demonstrated that Mr. Raddatz did not know that he suffered from an aortic aneurysm. If our argument fails to meet the standard needed to reinstate his insurance policy, please provide our office with details of additional information that will be needed to reinstate his health insurance policy. We greatly appreciate your prompt and continued attention to this matter and would like a response by Friday, May 5. Thank you very much.

Dr. Babs Waldman, M.D.
Health Care Bureau Medical Director
Office of the Illinois Attorney General
100 W. Randolph Street, 12th Floor
Chicago, Illinois, 60601

Sincerely,

Babs Waldman, M.D.
Medical Director
[redacted]
Fax: [redacted]

Anthem Blue Cross and Blue Shield
P.O. Box 37810
Louisville, KY 40233-7810

Anthem.

January 5, 2007

CERTIFIED MAIL [redacted]

[redacted]

COPY

ID#: [redacted]

De[redacted]

As stated in our letter of December 8, 2006 it has come to our attention that your application for the Blue Access policy, offered by Anthem Insurance Company, contains incorrect and/or incomplete medical information. We have received and reviewed your December 18, 2006 letter of explanation and appreciate you allowing us the time to respond.

The application you completed asks the following question(s):

2. Has any person applying for coverage in the past 5 years had any diagnosis, consultation, treatment, testing or taken any medication or received follow up treatment or examination for:

    a. Allergies, asthma, emphysema, bronchitis, chronic obstructive pulmonary disease, sleep apnea or other disease or disorder of the lungs or respiratory system?

[redacted]

The above question was answered "no" on your application. Had we known of your history of chronic obstructive pulmonary disease, coverage would have been declined.

Therefore, your coverage is rescinded. We intend to recover full payments made on claims submitted. All claims that are currently pending will be denied. Any premium fees paid will be refunded within approximately 30 business days, minus any amount that is applied toward claim payments that have been made for this member.

Please be advised that you will not receive a Certificate of Credible Coverage since your policy has been rescinded.

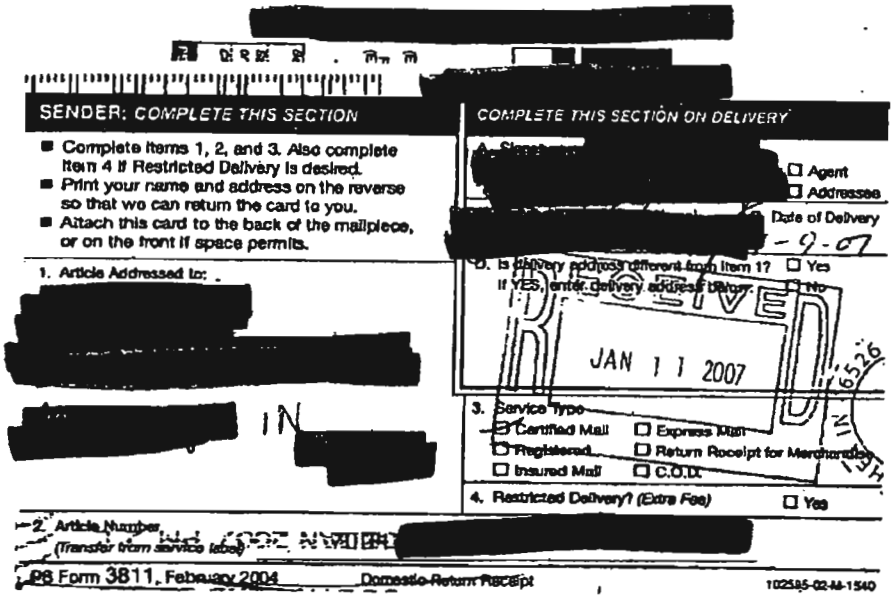
You have the right to appeal this decision. To initiate the appeals process, please forward your request for an appeal along with any additional information to the following address: Anthem Blue Cross Blue Shield, Appeals Department, P. O. Box 33200, Louisville, KY, 40232-3200. If you prefer, you may fax your appeal to (502) 889-3034.

You and/or your dependents may be eligible for health insurance coverage under The Indiana Comprehensive Health Insurance Association (ICHIA), which has been created by Indiana Law for residents who, for health reasons, have difficulty obtaining standard health insurance coverage. It is supported by all Indiana health insurance companies, and is overseen by the state government. If you are interested in obtaining more information about this program, please contact Indiana Comprehensive Health Insurance Association toll-free at [redacted]

Thank you for your attention to this matter. Should you have any questions, please call me at [redacted]

Sincerely,

[redacted]
Anthem Blue Cross and Blue Shield


SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

COMPLETE THIS SECTION ON DELIVERY

☐ Agent
☐ Addressee

Date of Delivery 1-9-07

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

RECEIVED
JAN 11 2007

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number
(Transfer from service label)

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

01/24/2007 13:03 [redacted] MJ LAW OFFICE

[redacted]
Attorney at Law
Personal Injury & Estate Planning included in areas of practice

[redacted]

ANTHEM BLUE CROSS & BLUE SHIELD
P.O. Box 37810
Louisville, KY 40233-7810

COPY

IN RE: [redacted]

Dear Ms. [redacted]

On January 5, 2007, you wrote [redacted] advising him that Anthem Blue Cross and Blue Shield had rescinded his health insurance coverage because of his response to a particular question on his health insurance application as to whether he had any diagnosis, consultation, treatment or testing specifically for chronic obstructive pulmonary disease. He answered no because his physician, Dr. [redacted] and Dr [redacted]'s nurse practitioner never used the term COPD or chronic obstructive pulmonary disease when discussing his history of cigarette smoking and the chronic problems that arise from tobacco usage in an appointment which preceded his application for health insurance

I have enclosed a copy of a letter from Dr. [redacted] dated January 9, 2007 wherein he specifically indicates that he did not explain to [redacted] that he was describing COPD while discussing the chronic problems of tobacco usage with him. Neither Dr. [redacted] or his nurse practitioner had any recollection that they ever actually sat down and talked with [redacted] about the first diagnosis of COPD and that [redacted] may well be correct that it was mid year 2006 before that diagnosis was ever given to him

For these reasons, we ask that Anthem reinstate his health insurance coverage immediately retroactive to the date of rescission. I am also faxing a copy of this letter to the Anthem Blue Cross and Blue Shield Appeals Department seeking the above requested relief

[redacted] medical condition is grave and he is scheduled for surgery in less than two weeks. If he suffers any harm, whether financially or physically, from this denial of insurance coverage, he will most certainly seek the appropriate remedies in court

Thank you for your consideration to this letter. If you would, please contact me upon receipt to discuss Anthem's response

Very Truly Yours,

[redacted]

[redacted]
Enclosure
[redacted]

	WELLPOINT	Committee Decision: Rescind ☒ No Retroaction ☐ Pending more info ☐

Committee Review Date:	HCID#, NAME, Member Code, Plan:	Application Signature Date:	Effective Date of Policy:
May [redacted], 2007	[redacted] Individual KeyCare Preferred	December [redacted] 2006	December [redacted], 2006

Date Referral Received:
April [redacted] 2007

Claim/Notification eliciting investigation:
Claim for dx 311 (depression) was flagged on the portability query.

Application/Health Statement :
Clean application; weight of 170 and height 5'3"

UNDERWRITING HISTORY
Approved Level 1

RELEVANT MEDICAL HISTORY PRIOR TO EFFECTIVE DATE:

RELEVANT MEDICAL HISTORY POST EFFECTIVE DATE:
Documented weight of 213 pounds and height 5'3" on January [redacted], 2007 (See page 5 of the medical records)

MEDICAL UNDERWRITING GUIDELINE(S):
Maximum weight for her height is 193 pounds

Health questions answered "no", should be "yes":
Weight portion of the application was incorrect

Reviewing Underwriter:
[redacted]

Comments: We did not receive a response from Mrs. [redacted]

[redacted]	[redacted]	[redacted]
RVP Individual Underwriting East Region	RVP, Medical Director	Director, Medical Management

Anthem Blue Cross and Blue Shield
Post Office Box 13047
Roanoke, Virginia 24030-3047

Anthem.

IMPORTANT INFORMATION ABOUT YOUR POLICY

April [redacted], 2007

[redacted] VA [redacted]

RE: ID No. [redacted]

Dear Mrs. [redacted]

I am writing to request your help in resolving a matter concerning your application for the Individual KeyCare Preferred program, your current health care coverage. The application includes questions about the medical history of the individual applying for coverage. Answers to these questions are evaluated along with any information obtained during the claims review process. Through this process, we learned that your history of psoriasis and hemorrhoids was not noted on your application. We also learned that you have a documented weight of 213 pounds on January [redacted] 2007 which would indicate that the weight on your application is inaccurate. For your reference, I have enclosed a copy of your application.

Please clarify in writing why these conditions and lifestyle information were not included on your application, then send your letter to my attention by **April [redacted] 2007**. Your written response is required for us to determine the future status of your contract with Anthem Blue Cross and Blue Shield. This review of your policy must be completed before any outstanding claims can be considered for payment. As explained in your policy, omitting important information from an application may result in cancellation of your coverage.

IMPORTANT NOTICE

If we do not receive a written response for our review by April [redacted], 2007, your Individual KeyCare Preferred coverage will be cancelled retroactive to its original effective date.

[redacted]

Anthem Blue Cross and Blue Shield
Post Office Box 13047
Roanoke, Virginia 24030-3047

Anthem.

Ms. [redacted] I appreciate your help as we work to resolve this matter. If you have any questions, our Member Liaison will be glad to assist you at [redacted]

Sincerely,

[redacted]
Underwriting Auditor

Enclosure

cc: File

[redacted]

Committee Review Date: 3/22/07 State: Texas 90 Day Date: 4/15/07	UNICARE.	Committee Decision Rescind ☐ No Retroaction ☐ Retro Waiver ☐ Retro Rate Up ☐

Member Name: [redacted]

HCID Number: [redacted] **MC Number:** MC40 [redacted]

Application Signature Date: 4/16/06 **Effective Date of the Policy:** 5/1/06 **Plan:** HSA 3 $5000/$10000

Membership Information: Active **Referral Source:** MRU **Date of Referral:** 1/[redacted]/07

Date claim received that was sent for review: 11/23/06 **Diagnoses on Claim:** Lump or Mass in Breast

Medication Listed on Intelliscript: Tetracycline and Tobramycin
Medication Listed on Reviewpoint: Boniva, Prometrium

Application/Health Statement:
- Height 5 feet 4 inches and weight 185 pounds.
- 01[redacted]2002 Ovarian. Laproscopic removal

Underwriting History:
Approved Preferred

Relevant Medical History Prior to Effective Date:
Provider: [redacted]
- 03-[redacted]2005 Bone density-Osteopenia. Start Actonel.
- 03-[redacted]2006 Meds: Actonel

Relevant History Post Effective Date:
An offer letter for waiver 73U was sent on 2/16/07 with no response

Medical Underwriting Guidelines:
- Osteopenia requires prescribed oral medications waiver 73U for 10 years would have been applied per MUG 733
- Recommend to rescind due to no response to offer sent on February 16, 2007

Other Medical History:
None

Health Questions Answered "NO" should be Yes:
Sect 6 question 27

Reviewing Underwriter: [redacted]

[redacted]	[redacted]	[redacted]
Director Ind/Sm Grp Underwriting	VP Medical Director	VP & GM Ind /Sm Grp Unicare

Please Print
In Black Ink

Policy #: [redacted] Order # [redacted]

APPLICATION FOR SHORT TERM MEDICAL INSURANCE
GOLDEN RULE INSURANCE COMPANY -- LAWRENCEVILLE, ILLINOIS 62439

No application will be accepted if received by Golden Rule at its Lawrenceville or Indianapolis Office more than 15 days after the date signed.

ALTERED APPLICATIONS WILL NOT BE ACCEPTED.

PROPOSED INSURED [redacted] (First / Middle Initial / Last) 6 22 1958 (Birth Date) 49 (Age) ☑ Male ☐ Female (Sex)

RESIDENT ADDRESS [redacted] (Street / City / State / ZIP / Telephone No.)

1. Are any of your dependents to be covered under the policy/certificate? ☑ Yes ☐ No If Yes, give details below.

Dependent's First Name	Relationship to You	Date of Birth*	Dependent's First Name	Relationship to You	Date of Birth*
[redacted]	[redacted]	3/3/1960			
[redacted]	[redacted]	7/8/1992			
[redacted]	[redacted]	7/12/1994			

*If anyone named above is less than 30 days old, long-form application GRI-AP-107-21 must be used. See "Effective Date" section of brochure.

		Yes	No
2.	Are you or is any family member (whether or not named in this application) an expectant mother or father? If yes, long-form application GRI-AP-107-21 must be used. See "Effective Date" section of brochure.	☐	☑
3.	Have you or anyone named above been declined for insurance due to health reasons? If yes, long-form application GRI-AP-107-21 must be used. See "Effective Date" section of brochure.	☐	☑
4.	Have you or any person named in Question 1 lived in the 50 states of the USA or the District of Columbia for less than the past 12 months? If yes, state the name of each person: [redacted] (The person(s) named will not be covered under the policy/certificate.)	☐	☑
5.	Do you or any person named in Question 1 now have hospital or medical expense insurance that will not terminate prior to the requested effective date? If yes, state the name of each person: [redacted] (The person(s) named will not be covered under the policy/certificate.)	☐	☑
6.	Within the last 5 years, have you or anyone listed on the application received medical or surgical consultation, advice, or treatment, including medication, for any of the following: liver disorders, kidney disorders, emphysema, diabetes, cancer, heart or circulatory system disorders (including high blood pressure), alcohol or drug abuse or immune system disorders, including HIV infection, or tested positive for HIV infection? If yes, state the name of each person: [redacted] (The person(s) named will not be covered under the policy/certificate.)	☐	☑

DEDUCTIBLE: ☐ $250 ☐ $500 ☑ $1,000 ☐ $1,500 ☐ $2,500 **REQUESTED EFFECTIVE DATE:** 12 1 2007
(See Statement of Understanding section below.)

MONTHS OF COVERAGE: ☐ 1 MO. ☐ 2 MO. ☑ 3 MO. ☐ 4 MO. ☐ 5 MO. ☑ 6 MO.

STATEMENT OF UNDERSTANDING

I have read this application and represent that the information shown on it is true and complete. I understand that: (a) no insurance will become effective unless my application is approved and the appropriate premium is actually received by Golden Rule at its Lawrenceville or Indianapolis Office with this application; (b) no benefits will be paid for a health condition that exists prior to the date insurance takes effect; and (c) if coverage is issued, the coverage will not be a continuation of any prior coverage. Incorrect or incomplete information on this application may result in voidance of coverage and claim denial. The information provided in this application, and any supplement or amendments to it, will be made a part of any policy/certificate which may be issued. I understand that for an application sent by any electronic means, insurance, if approved, will be effective the later of: (i) the requested effective date; or (ii) the day after receipt by Golden Rule. I understand that for a mailed application, insurance, if approved, will be effective the later of: (i) the requested effective date; or (ii) the day after the postmark date affixed by the U.S. Postal Service. If mailed and not postmarked by the U.S. Postal Service or if the postmark is not legible, the effective date will be the later of: (i) the requested effective date; or (ii) the date received by Golden Rule at its Lawrenceville or Indianapolis Office. I understand that the broker is only authorized to submit the application and initial premium and may not change or waive any right or requirement.

X [redacted]
Proposed Insured's Signature or Parent/Legal Guardian if proposed insured is a child

X [redacted]
State where you signed this application

X 11/26/2007
Date you signed and read application

[redacted]
Licensed Agent or Broker (Please Print)

[redacted]
Individual Producer #

Important Note:
"Postmark date" means the date of the postmark as affixed by the U.S. Postal Service.

11/26/2007 - 11:25:51 AM

GRI-AP-108-21

Note: P.O. Boxes are [redacted]

396D-G-0907

07[redacted]

Policy #: [redacted] Order #: [redacted]

To Continue Your Application for Coverage, You Must Become A Member Of FACT

Read and fill out the following FACT Membership Enrollment Form.

FACT MEMBERSHIP ENROLLMENT FORM

I hereby enroll for Full Associate membership in the FEDERATION OF AMERICAN CONSUMERS AND TRAVELERS (FACT). Upon completion of this enrollment form and payment of initial dues ($3 monthly), I understand that: (a) I will be entitled to FACT's benefits; (b) these benefits may change from time to time; (c) my membership will become effective on the day this enrollment form is dated and signed; (d) I am eligible to apply for association group insurance; and (e) I authorize the release of my name and address listed on the Golden Rule Insurance Company Application for Short Term Medical Insurance to FACT.

X [redacted] Member's Signature X 11/26/2007 Date

If you wish to apply for association group insurance, please complete the application.

FACT ENFO STM 0105

Payment Options: *Must choose one*

☐ **Single Payment: Check or money order $ Amt.** [redacted] (Total Single Payment on reverse. Includes $20 nonrefundable application fee.)
For this method of payment, you must make check or money order payable to FACT. (EFT also available with online application)

OR

☑ **Single Payment: Credit card $ Amt.** [redacted] (Total Single Payment on reverse. Includes $20 nonrefundable application fee.)
For this method of payment, you must complete the Credit Card Authorization below.

Credit Card Authorization ☐ Visa ☐ MasterCard
I authorize FACT or Golden Rule Insurance Company to bill my Visa/MasterCard account for the total payment.

[redacted] Account No. Expiration Date [redacted]

[redacted] Name on Credit Card X [redacted] Signature of Authorized User Phone No. [redacted]

Billing Address [redacted] City [redacted] State [redacted] ZIP [redacted]

NOTE: Some card issuers/financial institutions charge cash advance fees on insurance payments.

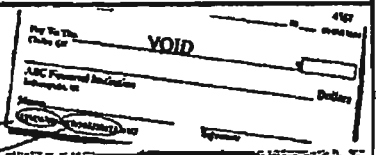
OR

☑ **Monthly Payment: Electronic Funds Transfer (EFT) $ Amt.** 176.47 (Total Initial Payment on reverse. First month amount (shown) includes a one-time $20 nonrefundable application fee.) Additional monthly EFT payments will be $20 less. For this method of payment, you must complete the EFT Authorization below.

Electronic Funds Transfer (EFT) Authorization

I (we) hereby authorize FACT or Golden Rule to initiate debit entries to the account indicated below. I also authorize the named depository to debit the same to such account.

I agree this authorization will remain in effect until you actually receive written notification of its termination from me.



Nine-digit Check Routing No. [redacted] Checking Account No. [redacted]

Financial Institution

Name [redacted] Address [redacted]

City [redacted] State [redacted] ZIP [redacted]

Draft On 15 Day X [redacted] Account Holder's Signature 11 28 2007 Date Signed

In Tennessee and Texas, drafts may only be scheduled on 1) the premium due date; or 2) up to 10 days after the due date.

[redacted] Account Holder's E-mail Address

11/26/2007 - 11:25:51 AM

07[redacted]

Golden Rule
A UnitedHealthcare Company

COPY

April 18, 2008

[redacted]

Identification No: [redacted]
Control No: [redacted]
Claimant: [redacted]
Insured: [redacted]

Dear [redacted]

When reviewing claims, we sometimes obtain medical records to help us resolve claim issues. As part of this routine process, we obtained medical information for you from [redacted]

During our review of your information, we learned there was prior medical history that may have impacted our decision to provide you with health coverage. Therefore, we are sending your information to our Underwriting Department for review, and we will keep you informed as our review progresses.

You should continue to pay your premiums. However, these premiums will be conditional and may be returned to you if we determine that material misstatements were made in the application for insurance.

Golden Rule expressly reserves its rights under the policy, including, but not limited to, those under the Time Limit on Certain Defenses provision, the Preexisting Conditions provision, and the Incontestability provision.

After our review is complete, we will let you know if your coverage will be affected in any way.

Sincerely,

[redacted]
Claim Department

Golden Rule Insurance Company
712 Eleventh Street
Lawrenceville, Illinois 62439
www.goldenrule.com

07177886 [redacted]

Golden Rule
A UnitedHealthcare Company

COPY

May 2, 2008

[redacted]

Identification No: [redacted]
Claimant: [redacted]
Insured: [redacted]

Dear [redacted]

Your request for benefits has been reviewed very carefully. We want to let you know the result of our review.

The Application for Coverage:

Before we can issue health insurance coverage, a customer fills out an application. We use the application to determine if we can offer coverage and rely on this information when we agree to provide coverage for a customer.

If the application is approved, a copy of it is attached and made part of the certificate. We do this so the customer can check the answers and let us know if any information is missing or incorrect. On the front of the certificate, it says "**Check the attached application.** If it is not complete or has an error, please let *us* know. An incorrect or incomplete application may cause *your* certificate to be voided and claims to be reduced or denied."

New Information From Our Review:

During our review, we requested and received medical records from [redacted] These medical records indicate that information was incorrect or missing from your application. This information would have changed the original decision to issue coverage.

According to the information we received, the answer to Question(s) 6 should have been "Yes" with respect to your medical history. The application should have also contained additional information in response to the question. A copy of the application is enclosed for your review.

Golden Rule Insurance Company
712 Eleventh Street
Lawrenceville, Illinois 62439
www.goldenrule.com

07[redacted]

The records we received noted that you were seen at [redacted] with a history of and treatment for alcohol abuse since at least November 28, 2006, up until at least January 19, 2007.

From November 28, 2006, up until at least August 16, 2007, it is noted by [redacted] of a history and treatment for hypertension.

How the New Information Affects Your Coverage:

If this information had been shown correctly on your application, our underwriters would have been unable to issue your coverage.

Now that we are aware of this information, we need to take the same action we would have taken if we had been aware of this information when you applied for insurance.

Your coverage has been voided. This means it is as though it had never been approved or issued. This also means:

- We will return all premium paid;
- We will not collect any more premium;
- We will not provide coverage or pay any claims; and
- We have no liability for any current or future claims.

There may be additional information that was missing or incorrect on your application. Golden Rule reserves the right to assert any other material misstatements as reason to void your coverage. By taking this action, we are not waiving any rights under the provisions of the certificate, including, but not limited to, the preexisting conditions provision.

Premium Refund:

Enclosed is a draft for payment of $922.82 to refund all premiums paid for your coverage. This draft also includes membership fees for Federation of American Consumers and Travelers (FACT). Any premiums you may have paid recently will be refunded to you as soon as we receive and identify them. Please note that there is a release on the back of the premium draft. By cashing the premium refund draft, you are accepting our decision to void your certificate.

07[redacted]

Please note that if the premium refund draft is not endorsed by the payee or if the release on the back is altered, Golden Rule will not pay the draft, you will not receive the funds, and your bank may charge you penalties or fees.

Your FACT Membership:

We will not continue to collect your FACT membership dues. As we explained above, your premium refund draft includes the membership fees we collected on behalf of FACT. We have not recovered this amount from FACT. You are still a member. If you wish to remain a member, you should arrange to send your membership fee directly to FACT. Their toll free number is 1-800-USA-FACT (1-800-872-3228), or you may write to them at:

FACT
Membership Service Office
P.O. Box 104
Edwardsville, IL 62025

Summary:

Since there is no coverage, for the reasons explained above, no present or future claims will be paid.

If you have additional information you believe would change our decision, please send it to us. We will review the information and reply to you promptly.

Sincerely,

[redacted]
Claims Review

Enclosure

07177886
L08127500700001
L08127500700001

MICHIGAN

[redacted]

I hereby enroll for Full Associate membership in the FEDERATION OF AMERICAN CONSUMERS AND TRAVELERS (FACT). Upon completion of this enrollment form and payment of initial dues ($3 monthly), I understand that: (a) I will be entitled to FACT's benefits; (b) these benefits may change from time to time; (c) my membership will become effective on the day this enrollment form is dated and signed; (d) I am eligible to apply for association group insurance; and (e) I authorize the release of my name and address listed on the Golden Rule Insurance Company Application for Insurance to FACT.

Member's Signature X [redacted] Date X 1/31/07

If you wish to apply for association group insurance, please complete the application below.

FACT ENPO 0105

[redacted]

GOLDEN RULE INSURANCE COMPANY
APPLICATION FOR INSURANCE

To be filled out personally by the applicant(s). PLEASE PRINT IN BLACK INK. Do not separate application pages

[redacted]

	Name (Last, First, M.I.)	Marital Status	Social Security Number	Birth Date	Age	Sex	Height	Weight
1. Henry (You)	[redacted] C.	☒M ☐S	[redacted]		48	M	5'10	185
2. Spouse	[redacted] M.		[redacted]		41	F	5'2	160
3. Dependent Children	Name (Last, First, M.I.)			Birth Date	Age	Sex	Height	Weight
a.	[redacted] L.		Not Required	[redacted]	18	F	5'2	99
b.	[redacted] M.			[redacted]	15	F	4'11	97
c.								
d.								
e.								

4. Primary Applicant's Address (P.O. Boxes are not acceptable): [redacted] (Street) (City) (State) (ZIP)

5. Phone Numbers: [redacted] (Home) (Other) (Best number and time to call) (E-mail Address)

6. Payor (if not You): Sons (Name) [redacted] (Street) (City) (State) (ZIP)

7. Your Beneficiary: [redacted] (Name) [redacted] (Relationship) 47 (Age) You will be the beneficiary for your spouse.

8. Your Occupation: SALES Date Hired: 1985 9. Total Annual Household Income: ☐$15,000 or less ☐$15,001 to $35,000 ☐$35,001 to $50,000 ☐$50,001 to $75,000 ☐$75,001 to $99,999 ☐$100,000 or more

Prior Employment (if within 2 years): _____

10. Primary Applicant's Mother's Maiden Name: [redacted] (Last Name Only) Spouse's Mother's Maiden Name: [redacted] (Last Name Only)

INDY SUPPORT/ISSUE
FEB 0 2 2007
V. MAXWELL

Jan 27 2007 02:55:50 pm

GRI-AP-107-21 Primary Applicant's Initials [redacted] Spouse's Initials [redacted] Date 1/31/07 122D-0806

1

46

09085412

REPS [redacted] PAGE 02

PAGE 02

COVERAGE INFORMATION

11. Requested Effective Date: 2/1/07 Requested Health Class: Primary: ☐ Preferred ☐ Standard ☐ Tobacco (if question 32 is yes)
Plan includes Preferred Network; if not wanted, check here ☐ Spouse: ☐ Preferred ☐ Standard ☐ Tobacco (if question 32 is yes)
Network Name: UHN

Copay Plans	HSA Plans			Base Plans	
☐ Copay Select[SM] ☐ $ 500	☑ HSA 100[SM]	Single	Family	☐ Plan 100[SM]	☐ $ 500 (Saver 80 only)
☐ $1,000	☐ HSA Saver[SM]	☐ $1,050	☐ $2,100	☐ Plan 80[SM]	☐ $1,000 (Saver 80 only)
☐ $1,500		☐ $1,800	☐ $3,600	☐ Saver 80[SM]	☐ $1,500 (Saver 80 only)
☐ $2,500		☐ $2,700	☐ $5,400		☐ $2,500
☐ Copay Saver[SM] ☐ $2,000		☐ $3,600	☐ $7,500		☐ $3,500
		☐ $5,000	☐ $10,000		☐ $5,000
☐ Term Life Benefit	☐ Term Life Benefit			☐ Term Life Benefit ☐ Preventive Care	
☐ Preventive Care (not available with Copay Select)	☐ Preventive Care			☐ Supplemental Accident	
☐ Supplemental Accident	☐ Hospital Indemnity Rider			☐ $2,500 ☐ $4,000 Maximum Maternity	
☐ $2,500 ☐ $4,000 Maximum Maternity				☐ Prescription Drug Card (not available with Saver 80)	

Enrollment and Premium Payment Options

12. Initial Payment With Application
☐ Check ☐ P.A.C. (EFT with on-line app. only) ☑ Credit Card → Initial Payment Credit Card Authorization
Ongoing Payments
☑ Monthly P.A.C. (EFT) ☐ Quarterly Direct Bill ☐ List Bill (include forms)

FACT Dues	$ 3.00	
Base Premium Amount	+ 432 [illegible]	
Term Life Benefit	+ —	Optional
Preventive Care	+ —	Optional
Supplemental Accident	+ —	Optional
Maternity Benefit	+ —	Optional
Prescription Drug Card	+ —	Optional
HSA Deposit	+ —	$25 Monthly Minimum (only with HSA)
Total Monthly Payment	= $ 435 [illegible]	→ If Quarterly → X3 = $ ____ Total Quarterly Payment
One-Time HSA Set-Up Fee	+ —	$10 only with HSA
One-Time HSA Indemnity Rider	+ —	One-Time HSA Indemnity Rider
Initial Payment	= $ 435 [illegible]	Make check payable to "FACT." = $ ____ Initial Payment ←

Type of Card ☐ [illegible] ☐ Visa Expiration Date [redacted] Month Year
Security Code [redacted] (3 digits in signature box)
Name [redacted]
Billing Address [redacted] State Zip
Card Number [redacted]
X [redacted] Signature of Authorized User

OTHER COVERAGE

13. Within the last 62 days, has any applicant been covered by any type of medical insurance? If yes, complete chart below. ..... Yes ☑ No ☐
Your signature on this application indicates your agreement to terminate any existing coverage listed below as being replaced (see (7) above the signature lines).

Applicant's Name	Company Name	Policy/Certificate Number	Type (Individual, Employer Group, Short Term, COBRA, Medicaid, Other)	Is this to be replaced?	Termination Date
[redacted]	[redacted]			YES	FEB.

14. Will the term life benefit replace any existing life insurance? Company Name ____ Policy # ____ Yes ☐ No ☑

15. Has any applicant ever had an application or policy voided, declined, postponed, rated, or charged an extra premium, or had coverage modified (including medical exclusion riders) by any health or life insurer? (If yes, list name and give details.) ..... Yes ☐ No ☑
Person: ____ Company: ____ Action Taken: ____
Date: ____ Reason for Action: ____

16. Has any applicant previously applied for, or been covered by, Golden Rule? ..... Yes ☐ No ☑
If yes, who? ____ Policy/Certificate # ____

QRHAP-107-21 Primary Applicant's Initials [redacted] Spouse's Initials [redacted] Date 1/31/07 122D-0606
Jan 27 2007 02:56:50 pm

47

COVERAGE INFORMATION

11. Requested Effective Date: 2/1/07 Requested Health Class: Primary: ☐ Preferred ☐ Standard ☐ Tobacco (If question 32 is yes)
Plan Includes: Preferred Network; if not wanted, check here ☐ Spouse: ☐ Preferred ☐ Standard ☐ Tobacco (If question 32 is yes)
Network Name: UHN

Optional Coverage	Deductible		Single	Family	Optional Coverage	
☐ Copay Select[SM]	☐ $ 500	☑ HSA 100*	☐ $1,050	☐ $ 2,100	☐ Plan 100*	☐ $ 500 (Saver 80 only)
	☐ $1,000	☐ HSA Saver*	☐ $1,800	☐ $ 3,600	☐ Plan 80[SM]	☐ $1,000 (Saver 80 only)
	☐ $1,500		☐ $2,700	☐ $ 5,400	☐ Saver 80[SM]	☐ $1,500 (Saver 80 only)
	☐ $2,500		☐ $3,600	☐ $ 7,600		☐ $2,500
			☐ $5,000	☐ $10,000		☐ $3,600
☐ Copay Saver[SM]	☐ $2,000					☐ $5,000
☐ Term Life Benefit		☐ Term Life Benefit			☐ Term Life Benefit	☐ Preventive Care
☐ Preventive Care (Not Available with Copay Select)		☐ Preventive Care			☐ Supplemental Accident	
☐ Supplemental Accident		☐ Hospital Indemnity Rider			☐ $2,500 ☐ $4,000 Maximum Maternity	
☐ $2,500 ☐ $4,000 Maximum Maternity					☐ Prescription Drug Card (not Available with Saver 80)	

EXCLUSIONS FOR PREEXISTING CONDITIONS

12. Initial Payment With Application
☐ Check ☐ P.A.C. (EFT with on-line app. only) ☑ Credit Card →
Ongoing Payments
☑ Monthly P.A.C. (EFT) ☐ Quarterly Direct Bill ☐ List Bill (Include forms)

Initial Payment Credit Card Authorization
I authorize FACT or Golden Rule to bill my Visa/MasterCard account for the initial Payment. If quarterly billing requested, the initial Payment will be for three months plus any applicable fees.
Type of Card: ☐ MasterCard ☐ Visa Expiration Date: [redacted] Month Year
Security Code [redacted]
Name [redacted]
Billing Address [redacted]
Card Number [redacted]
X [redacted] Signature of Authorized User

FACT Dues	$ 3.00			
Base Premium Amount	+ 432.35			
Term Life Benefit	+ —	Optional		
Preventive Care	+ —	Optional		
Supplemental Accident	+ —	Optional		
Maternity Benefit	+ —	Optional		
Prescription Drug Card	+ —	Optional		
HSA Deposit	+ —	$25 Monthly Minimum (only with HSA)		
Total Monthly Payment	= $ 435.35	If Quarterly →	X3 = $	Total Quarterly Payment
One-Time HSA Set-Up Fee	+ —	$10 only with HSA	+	One-Time HSA Set-Up Fee
One-Time HSA Indemnity Rider	+ —		+	One-Time HSA Indemnity Rider
Initial Payment	= $ 435.35	Make check payable to "FACT"	= $	Initial Payment ←

OTHER COVERAGE

	Yes	No
13. Within the last 62 days, has any applicant been covered by any type of medical insurance? If yes, complete chart below. Your signature on this application indicates your agreement to terminate any existing coverage listed below as being replaced (see (*) above the signature lines).	☑	☐

Applicant's Name	Company Name	Policy/Certificate Number	Type (Individual, Employer Group, Short Term, COBRA, Medicaid, Other)	Is this to be replaced?	Termination Date
[redacted]	[redacted]			YES	FEB.

	Yes	No
14. Will the term life benefit replace any existing life insurance? Company Name _____ Policy # _____	☐	☑
15. Has any applicant ever had an application or policy voided, declined, postponed, rated, or charged an extra premium, or had coverage modified (including medical exclusion riders) by any health or life insurer? (If yes, list name and give details.)	☐	☑
Person: _____ Company: _____ Action Taken: _____		
Date: _____ Reason for Action: _____		
16. Has any applicant previously applied for, or been covered by, Golden Rule?	☐	☑
If yes, who? _____ Policy/Certificate # _____		

GRI-AP-107-21 Primary Applicant's Initials [redacted] Spouse's Initials [redacted] Date 1/31/07 1220-0606
Jan 27 2007 02:56:50 pm

1 09085412

PAGE 03 REPS [redacted] FACTT 2007/10/20

DRIVING

		Yes	No
17.	In the last 24 months, has any applicant participated in driving any type of motorcycle?	☐	☑
	If yes, please answer the following questions:		
	a. Name of applicant(s)? _____		
	b. Does the applicant have a valid motorcycle license?	☐	☐
	c. Within the last 24 months, has the applicant had his/her license suspended or revoked?	☐	☐
	d. Within the last 24 months, has the applicant, while operating a motor vehicle, been involved in an accident or received a moving violation? If yes, provide details in "Medical History Details."	☐	☐

[illegible]

IMPORTANT! PLEASE PROVIDE DETAILS OF EACH YES ANSWER IN "MEDICAL HISTORY DETAILS."

		Yes	No
18.	Is any family member (whether or not named in this application) pregnant or an expectant mother or father?	☐	☑
19.	Do any applicants, other than dependent children, not read, write, speak, and understand the English language?	☐	☑
20.	Do you have an adoption pending?	☐	☑
21.	In the last 6 months, has any applicant taken, or been advised to take, medication or received medical advice or treatment of any kind?	☐	☑
22.	Within the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease or disorder of the:		
	a. gallbladder?	☐	☑
	b. pancreas or liver?	☐	☑
	c. joins or spine?	☐	☑
	d. kidney?	☐	☑
	e. eyes, ears, or nose?	☐	☑
	f. mouth, throat, or jaw?	☐	☑
23.	In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of:		
	a. high blood pressure?	☐	☑
	b. chest pain?	☐	☑
	c. headaches?	☐	☑
	d. paralysis?	☐	☑
	e. arthritis?	☐	☑
	f. convulsions or epilepsy?	☐	☑
	g. elevated cholesterol?	☑	☐
	h. sexually transmitted disease?	☐	☑
	i. cancer?	☐	☑
	j. diabetes or sugar in the blood or urine?	☐	☑
	k. stroke?	☐	☑
	l. tumor, cyst, polyp, lump, or growth of any kind?	☐	☑
	m. mental, emotional, or behavioral disorder?	☐	☑
24.	In the last 10 years, has any applicant:		
	a. had a complicated pregnancy or delivery?	☐	☑
	b. been hospital confined, had surgery, or discussed surgery?	☐	☑

		Yes	No
25.	In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease, disorder, or abnormality of the:		
	a. heart or circulatory system?	☐	☑
	b. nervous system?	☐	☑
	c. digestive system?	☐	☑
	d. muscular or skeletal system?	☐	☑
	e. respiratory system?	☐	☑
	f. male or female reproductive system, including infertility?	☐	☑
	g. urinary system?	☐	☑
	h. thyroid, breast, or other glands?	☐	☑
26.	In the last 10 years, has any applicant had any diagnosis or treatment of Acquired Immune Deficiency Syndrome (AIDS)?	☐	☑
27.	In the last 10 years, has any applicant had a persistent, recurrent fever greater than 100 degrees Fahrenheit for 3 weeks or more, unexplained chronic fatigue for one month or more, night sweats for one month or more, or a chronic cough for one month or more?	☐	☑
28.	In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any other disease, disorder, injury, or adverse finding, or had any adverse or abnormal test results?	☐	☑
29.	In the last 12 months, has any applicant experienced a weight gain or loss of 15 pounds or more?	☐	☑
30.	In the last 5 years, has any applicant had any indication, diagnosis, or treatment of an alcohol or drug dependency, problem, or abuse; or any alcohol- or drug-related arrest?	☐	☑
31.	Is any applicant currently, or in the last 5 years been, a user of alcoholic beverages in excess of 14 drinks per week? If yes, show who and how many drinks per week in "Medical History Details" (one drink equals: 12 oz. of beer; 4 oz. of wine; 1 oz. of hard liquor).	☐	☑
32.	Has any applicant smoked cigarettes or used tobacco in any form (including smokeless tobacco) or nicotine substitute within the past 12 months? (If yes, mark "Tobacco" in Question 11.)	☐	☑
33.	List in "Medical History Details" any additional doctors or other health care professionals that any applicant has consulted with or been treated by in the last 5 years, and give full details.		

Jan 27 2007 02:56:50 pm GRI-AA-101-21 Primary Applicant's initials [redacted] Spouse's initials [redacted] Date 1/31/07 122D-0606

09085412

DRIVING

	Yes	No
17 In the last 24 months, has any applicant participated in driving any type of motorcycle?	☐	☑
If yes, please answer the following questions:		
a. Name of applicant(s)? _____		
b. Does the applicant have a valid motorcycle license?	☐	☐
c. Within the last 24 months, has the applicant had his/her license suspended or revoked?	☐	☐
d. Within the last 24 months, has the applicant, while operating a motor vehicle, been involved in an accident or received a moving violation? If yes, provide details in "Medical History Details."	☐	☐

MEDICAL HISTORY — FOR ALL APPLICANTS

IMPORTANT! PLEASE PROVIDE DETAILS OF EACH YES ANSWER IN "MEDICAL HISTORY DETAILS."

	Yes	No
18. Is any family member (whether or not named in this application) pregnant or an expectant mother or father?	☐	☑
19. Do any applicants, other than dependent children, not read, write, speak, and understand the English language?	☐	☑
20. Do you have an adoption pending?	☐	☑
21. In the last 6 months, has any applicant taken, or been advised to take, medication or received medical advice or treatment of any kind?	☐	☑
22. Within the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease or disorder of the:		
a. gallbladder?	☐	☑
b. pancreas or liver?	☐	☑
c. joints or spine?	☐	☑
d. kidney?	☐	☑
e. eyes, ears, or nose?	☐	☑
f. mouth, throat, or jaw?	☐	☑
23. In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of:		
a. high blood pressure?	☐	☑
b. chest pain?	☐	☑
c. headache?	☐	☑
d. paralysis?	☐	☑
e. arthritis?	☐	☑
f. convulsions or epilepsy?	☐	☑
g. elevated cholesterol?	☑	☐
h. sexually transmitted disease?	☐	☑
i. cancer?	☐	☑
j. diabetes or sugar in the blood or urine?	☐	☑
k. stroke?	☐	☑
l. tumor, cyst, polyp, lump, or growth of any kind?	☐	☑
m. mental, emotional, or behavioral disorder?	☐	☑
24. In the last 10 years, has any applicant:		
a. had a complicated pregnancy or delivery?	☐	☑
b. been hospital confined, had surgery, or discussed surgery?	☐	☑
25. In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease, disorder, or abnormality of the:		
a. heart or circulatory system?	☐	☑
b. nervous system?	☐	☑
c. digestive system?	☐	☑
d. muscular or skeletal system?	☐	☑
e. respiratory system?	☐	☑
f. male or female reproductive system, including infertility?	☐	☑
g. urinary system?	☐	☑
h. thyroid, breast, or other glands?	☐	☑
26. In the last 10 years, has any applicant had any diagnosis or treatment of Acquired Immune Deficiency Syndrome (AIDS)?	☐	☑
27. In the last 10 years, has any applicant had a persistent, recurrent fever greater than 100 degrees Fahrenheit for 3 weeks or more, unexplained chronic fatigue for one month or more, night sweats for one month or more, or a chronic cough for one month or more?	☐	☑
28. In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any other disease, disorder, injury, or adverse finding, or had any adverse or abnormal test results?	☐	☑
29. In the last 12 months, has any applicant experienced a weight gain or loss of 15 pounds or more?	☐	☑
30. In the last 5 years, has any applicant had any indication, diagnosis, or treatment of an alcohol or drug dependency, problem, or abuse; or any alcohol- or drug-related arrest?	☐	☑
31. Is any applicant currently, or in the last 5 years been, a user of alcoholic beverages in excess of 14 drinks per week? If yes, show who and how many drinks per week in "Medical History Details" (one drink equals: 12 oz. of beer; 4 oz. of wine; 1 oz. of hard liquor).	☐	☑
32. Has any applicant smoked cigarettes or used tobacco in any form (including smokeless tobacco) or nicotine substitute within the past 12 months? (If yes, mark "Tobacco" in Question 11.)	☐	☑
33. List in "Medical History Details" any additional doctors or other health care professionals that any applicant has consulted with or been treated by in the last 5 years, and give full details.		

MEDICAL HISTORY DETAILS – FOR ALL APPLICANTS

Question Number	Person	Symptoms or Conditions	Dates	Treatment, Advice Given, Results, and Other Details	Name, Address, and Phone # of Doctor, Hospital, etc.
23(6)		Hyst [illegible]	[illegible]	Lupron 10 mg	[redacted]

Should you need more space to provide complete and accurate information, please use plain or lined paper, sign and date it, and check this box. ☐

APPLICANT'S AGREEMENT AND UNDERSTANDING

I certify that I have personally completed this application. I represent that the answers and statements on this application are true, complete, and correctly recorded. I Understand and Agree that: (1) this application and the payment of the initial premium do not give me immediate coverage; (2) unless Golden Rule agrees to an earlier date, coverage for illness begins on the 15th day after a person becomes insured for injury; (3) there will be no benefits for any loss incurred in the first year of coverage due to a preexisting condition; (4) incorrect or incomplete information on this application may result in voidance of coverage or claim denial; (5) this completed application, and any supplements or amendments, will be made a part of any policy/certificate which may be issued; (6) the broker is only authorized to submit the application and initial premium, and may not change or waive any right or requirement; and (7) continuation of other coverage existing on the Golden Rule effective date for more than 90 days after the Golden Rule effective date will void this coverage. I have received a Notice of Information Practices and a Conditional Receipt or Conditions Prior to Coverage.

Signed X 1/31/07 at [redacted]
Date City State

X [redacted]
Signature of Parent/Guardian (If You are a minor) Relationship

X [redacted]

X [redacted]

BROKER'S STATEMENT

Each question on the application was completed by the applicant(s). I have collected the initial premium and given the Notice of Information Practices and a Conditional Receipt or Conditions Prior to Coverage.

X [redacted]
Signature of Licensed Broker

[redacted]
Broker Number

I agree with the answer given for Question 14, "Will the term life benefit replace any existing life insurance?" (If the response shown for Question 14 does not reflect your understanding, please check this box and attach an explanation ☐). Does Not Apply

X [redacted]
Print Name

[redacted]

GRI-AP-107-21
Jan 27 2007 02:55:50 pm

122D-0606

51

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[redacted] 02/01/2007 11:53

PAGE 05

MEDICAL HISTORY DETAILS -- FOR ALL APPLICANTS

Question Number	Person	Symptoms or Conditions	Dates	Treatment, Advice Given, Results, and Other Details	Name, Address, and Phone # of Doctors, Hospitals, etc.
23(b)		Heart Catheterization	2004	Lipitor 10 mg	[redacted]
					[redacted]

Should you need more space to provide complete and accurate information, please use plain or lined paper, sign and date it, and check this box. ☐

I certify that I have personally completed this application. I represent that the answers and statements on this application are true, complete, and correctly recorded. I Understand and Agree that: (1) this application and the payment of the initial premium do not give me immediate coverage; (2) unless Golden Rule agrees to an earlier date, coverage for illness begins on the 15th day after a person becomes insured for injury; (3) there will be no benefits for any loss incurred in the first year of coverage due to a preexisting condition; (4) incorrect or incomplete information on this application may result in voidance of coverage or claim denial; (5) this completed application, and any supplements or amendments, will be made a part of any policy/certificate which may be issued; (6) the broker is only authorized to submit the application and initial premium, and may not change or waive any right or requirement; and (7) continuation of other coverage existing on the Golden Rule effective date for more than 30 days after the Golden Rule effective date will void this coverage. I have received a Notice of Information Practices and a Conditional Receipt or Conditions Prior to Coverage.

Signed X 1, 31, 07 at [redacted]
Date City State

X [redacted]

X _____
Signature of Parent/Guardian (if You are a minor) Relationship

X [redacted]

Each question on the application was completed by the applicant(s). I have collected the initial premium and given the Notice of Information Practices and a Conditional Receipt or Conditions Prior to Coverage.

X [redacted]
Signature of Licensed Broker

Broker Number [redacted]

I agree with the answer given for Question 14, "Will the form life benefit replace any existing life insurance?" (If the response shown for Question 14 does not reflect your understanding, please check this box and [redacted] ☐ Does not apply

X [redacted]

Print Full [redacted]

PREAUTHORIZED PAYMENT (BANK DRAFT) AUTHORIZATION - ONLY IF PAYING BY MONTHLY PAC

I (we) hereby authorize PACT or Golden Rule to initiate debit entries to the account indicated below. I also authorize the named depository to debit the same to such account.

I agree this authorization will remain in effect until you actually receive written notification from me (or either of us) of its termination.

Routing No. [redacted]

Checking Account No. [redacted]

Include Voided BLANK check!

Financial Institution's Name [redacted]

Address [redacted]

City, State, ZIP [redacted]

Draft On [redacted] 1/31/07
Day (Date Signed)

X [redacted]
(Signature of Policyholder)

HEALTH INSURANCE CERTIFICATION AND AUTHORIZATION TO OBTAIN AND DISCLOSE NONMEDICAL INFORMATION

This insurance coverage is not designed nor marketed as employer-provided insurance. This coverage does not comply with all your state's small-employer group health insurance laws. Therefore, this plan cannot be used, now nor at some future date, by you or an employer to provide insurance for employees.

I certify that:

(a) I am not employed by an employer with 2-50 employees; or

(b) I am employed by an employer with 2-50 employees; however, no portion of the premium is paid, either directly or indirectly, by my employer.

If you cannot certify to either (a) or (b) above, you are not eligible to apply for this plan.

By signing below, I certify that I understand that I am applying for personal health insurance that may never be used as employer-provided insurance.

9539-799

I authorize Golden Rule Insurance Company's Insurance Administration and Claims Departments to obtain information that they need to underwrite or verify my application for insurance. Any person, employer, insurance company, consumer reporting agency, or the Medical Information Bureau (MIB) having nonmedical information about my family or me is authorized to give it to Golden Rule's Insurance Administration and Claims Departments.

Golden Rule may also release this information about my family or me to the MIB or any member company for the purposes described in Golden Rule's Notice of Information Practices.

I (we) have received Golden Rule's Notice of Information Practices. This authorization shall remain valid for 30 months from the date below.

I (we) understand the following: A photocopy of this authorization is as valid as the original. I (we) or my (our) authorized representative may obtain a copy of this authorization by writing to Golden Rule. I (we) may request revocation of this authorization by writing to Golden Rule, as explained in Golden Rule's Notice of Information Practices. Golden Rule may condition enrollment in its health plan or eligibility for benefits on my (our) refusal to sign this authorization. The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by federal or state privacy laws.

I have read the above: Health Insurance Certification and Authorization to Obtain and Disclose Nonmedical Information.

Signed X 1/31/07 at [redacted]
Date City State

X [redacted]

X _____
Signature of Parent/Guardian (If You are a minor)

X [redacted]
Signature of Spouse (If to be covered)

AUTHORIZATION TO OBTAIN AND DISCLOSE HEALTH INFORMATION

I authorize Golden Rule Insurance Company's Insurance Administration and Claims Departments to obtain health information that they need to underwrite or verify my application for insurance. Any health care provider, the Medical Information Bureau (MIB), or insurance company having any information as to a diagnosis, the treatment, or prognosis of any physical or mental conditions about my family or me is authorized to give it to Golden Rule's Insurance Administration and Claims Departments. This includes information related to substance use or abuse.

I understand any existing or future requests I have made or may make to restrict my protected health information do not and will not apply to this authorization, unless I revoke this authorization.

Golden Rule may release this information about my family or me to the MIB or any member company for the purposes described in Golden Rule's Notice of Information Practices.

I (we) have received Golden Rule's Notice of Information Practices. This authorization shall remain valid for 30 months from the date below.

I (we) understand the following:

- A photocopy of this authorization is as valid as the original;
- I (we) or my (our) authorized representative may obtain a copy of this authorization by writing to Golden Rule;
- I (we) may request revocation of this authorization as described in Golden Rule's Notice of Information Practices;
- Golden Rule may condition enrollment in its health plan or eligibility for benefits on my (our) refusal to sign this authorization;
- The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by federal or state privacy laws regulating health insurers.

I have retained a copy of this authorization.

I have read the above: Authorization to Obtain and Disclose Health Information.

Signed X 1/31/07 at [redacted]
Date City State

X [redacted]

X _____
Signature of Parent/Guardian (If You are a minor)

X [redacted]
Signature of Spouse (If to be covered)

MONTHLY P.A.C. AUTHORIZATION - ONLY IF PAYING BY MONTHLY P.A.C.

I (we) hereby authorize FACT or Golden Rule to initiate debit entries to the account indicated below. I also authorize the named depository to debit the same to such account.

I agree this authorization will remain in effect until you actually receive written notification from me (or either of us) of its termination.

Routing No. [redacted]

Checking Account No. [redacted]

Include Voided BLANK check

Financial Institution's Name [redacted]

Address [redacted]

City, State, ZIP [redacted]

Draft On [redacted]

Day [redacted] 1/31/07 (Date Signed)

X [redacted] (Signature of Account Holder)

HEALTH INSURANCE CERTIFICATION AND AUTHORIZATION TO OBTAIN AND DISCLOSE NONMEDICAL INFORMATION

This insurance coverage is not designed nor marketed as employer-provided insurance. This coverage does not comply with all your state's small-employer group health insurance laws. Therefore, this plan cannot be used, now nor at some future date, by you or an employer to provide insurance for employees.

I certify that:

(a) I am not employed by an employer with 2-50 employees; or

(b) I am employed by an employer with 2-50 employees; however, no portion of the premium is paid, either directly or indirectly, by my employer.

If you cannot certify to either (a) or (b) above, you are not eligible to apply for this plan.

By signing below, I certify that I understand that I am applying for personal health insurance that may never be used as employer-provided insurance.

05JB-799

I authorize Golden Rule Insurance Company's Insurance Administration and Claims Departments to obtain information that they need to underwrite or verify my application for insurance. Any person, employer, insurance company, consumer reporting agency, or the Medical Information Bureau (MIB) having nonmedical information about my family or me is authorized to give it to Golden Rule's Insurance Administration and Claims Departments.

Golden Rule may also release this information about my family or me to the MIB or any member company for the purposes described in Golden Rule's Notice of Information Practices.

I (we) have received Golden Rule's Notice of Information Practices. This authorization shall remain valid for 30 months from the date below.

I (we) understand the following: A photocopy of this authorization is as valid as the original. I (we) or my (our) authorized representative may obtain a copy of this authorization by writing to Golden Rule. I (we) may request revocation of this authorization by writing to Golden Rule, as explained in Golden Rule's Notice of Information Practices. Golden Rule may condition enrollment in its health plan or eligibility for benefits on my (our) refusal to sign this authorization. The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by federal or state privacy laws.

I have read the above: Health Insurance Certification and Authorization to Obtain and Disclose Nonmedical Information.

Signed X 1/31/07 at [redacted] X [redacted]

Date City State Signature

X _____ X [redacted]

Signature of Parent/Guardian (If You are a minor) Signature of Spouse (If to be covered)

AUTHORIZATION TO OBTAIN AND DISCLOSE HEALTH INFORMATION

I authorize Golden Rule Insurance Company's Insurance Administration and Claims Departments to obtain health information that they need to underwrite or verify my application for insurance. Any health care provider, the Medical Information Bureau (MIB), or insurance company having any information as to a diagnosis, the treatment, or prognosis of any physical or mental conditions about my family or me is authorized to give it to Golden Rule's Insurance Administration and Claims Departments. This includes information related to substance use or abuse.

I understand any existing or future requests I have made or may make to restrict my protected health information do not and will not apply to this authorization, unless I revoke this authorization.

Golden Rule may release this information about my family or me to the MIB or any member company for the purposes described in Golden Rule's Notice of Information Practices.

I (we) have received Golden Rule's Notice of Information Practices. This authorization shall remain valid for 30 months from the date below.

I (we) understand the following:

- A photocopy of this authorization is as valid as the original;
- I (we) or my (our) authorized representative may obtain a copy of this authorization by writing to Golden Rule;
- I (we) may request revocation of this authorization as described in Golden Rule's Notice of Information Practices;
- Golden Rule may condition enrollment in its health plan or eligibility for benefits on my (our) refusal to sign this authorization;
- The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by federal or state privacy laws regulating health insurers.

I have retained a copy of this authorization.

I have read the above: Authorization to Obtain and Disclose Health Information.

Signed X 1/31/07 at [redacted] X [redacted]

Date City State Signature

X _____ X [redacted]

Signature of Parent/Guardian (If You are a minor) Signature of Spouse (If to be covered)

HEALTH SAVINGS ACCOUNT (HSA) APPLICATION (only if applying for HSA with Exante Bank)

By signing below, I acknowledge that:

- I wish to establish an HSA with Exante Bank as custodian.
- I understand and agree that my HSA will be opened under and governed by Exante Bank's Custodial and Deposit Agreement. Terms of this Agreement will be binding on me unless I close my account within 30 days. This document will be sent to me when my account is opened, along with Exante Bank's Privacy Policy and Schedule of Fees and Charges.
- I authorize Exante Bank to provide information about my HSA, including my account number, to Golden Rule, and those acting on behalf of Golden Rule or Exante Bank (if applicable), in connection with the establishment and maintenance of my HSA.
- I acknowledge that Golden Rule and all others acting on behalf of Golden Rule (if applicable), may provide information on my behalf to establish and maintain my HSA.
- I understand my monthly account statements will be made available to me electronically. I agree to notify Exante Bank if I wish to have statements mailed to my home address.
- If I have filled out the information to request an additional debit card, I hereby request Exante Bank to issue a debit card on my account to the person indicated and I acknowledge I will be liable for the use of the debit card by the Authorized User.
- I certify that the information provided in this application is true and complete.

X _____
Signature of Primary Applicant

Primary Applicant's
Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

For the USA Patriot Act: To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. When you open the account, we will ask for your name, street address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

Have you, within the last 6 months, been covered under another health insurance plan? ..... ☐ Yes ☐ No
Has your spouse? ..... ☐ Yes ☐ No

REQUEST FOR AN ADDITIONAL DEBIT CARD (OPTIONAL)

Authorized User's _____ _____
First Name Middle Initial

Authorized User's _____
Last Name

Authorized User's _____
Date of Birth

Authorized User's _____
Social Security No.

155X-0806

REVIEW BEFORE MAILING THE APPLICATION

Be sure:

- To read the current product brochure before completing the application for insurance.

Note:

- If you were previously insured by UnitedHealthcare, you must still fully complete this application accurately. Our underwriters do not have access to UnitedHealthcare underwriting and claims files.
- Broker must be licensed with Golden Rule in state where application is signed AND state where applicant resides.
- Coverage is not available if:
  - any family member is currently pregnant; or
  - the applicant has not resided in the U.S. for the last 12 consecutive months.
- Altered applications will not be accepted.
- Any person who knowingly presents false, incomplete, or misleading information in an application for insurance may be committing insurance fraud.
- The applicant will be notified of the actions taken within 45 days after the date of the application, or be given the reason for delay.
- There is no coverage until approved in writing by Golden Rule.
- P.O. Boxes are not accepted as a Primary Resident Address.
- Applications received by Golden Rule more than 15 days after the signed date will not be accepted.

Mail the Application and Related Forms Packet to the address below.

Be sure to include the following:

- Health insurance quote.
- Initial payment check made payable to "FACT."
- P.A.C. authorization and voided check (if paying monthly).

Mail to: Golden Rule Insurance Company
HEALTH APPLICATION
Golden Rule Building
7440 Woodland Drive
Indianapolis, Indiana 46278-1719

122D-0806

Jan 27 2007 02:55:50 pm

55

PAGE 07 FEB 01 2007 14:20

09085412 [redacted] 11:53 /002/10/20 PAGE.07

MULTI SAVINGS ACCOUNT HSA APPLICATION (Only complete if HSA not Elected)

By signing below, I acknowledge that:

- I wish to establish an HSA with Exante Bank as custodian.
- I understand and agree that my HSA will be opened under and governed by Exante Bank's Custodial and Deposit Agreement. Terms of this Agreement will be binding on me unless I close my account within 30 days. This document will be sent to me when my account is opened, along with Exante Bank's Privacy Policy and Schedule of Fees and Charges.
- I authorize Exante Bank to provide information about my HSA, including my account number, to Golden Rule, and those acting on behalf of Golden Rule or Exante Bank (if applicable), in connection with the establishment and maintenance of my HSA.
- I acknowledge that Golden Rule and all others acting on behalf of Golden Rule (if applicable), may provide information on my behalf to establish and maintain my HSA.
- I understand my monthly account statements will be made available to me electronically. I agree to notify Exante Bank if I wish to have statements mailed to my home address.
- If I have filled out the information to request an additional debit card, I hereby request Exante Bank to issue a debit card on my account to the person indicated and I acknowledge I will be liable for the use of the debit card by the Authorized User.
- I certify that the information provided in this application is true and complete.

X _____
Signature of Primary Applicant

Primary Applicant's
Social Security Number ___ ___ ___ - ___ ___ - ____

Per the USA Patriot Act: To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. When you open the account, we will ask for your name, street address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

Have you, within the last 6 months, been covered under another health insurance plan? ..... ☐ Yes ☐ No
Has your spouse? ..... ☐ Yes ☐ No

REQUEST FOR AN ADDITIONAL DEBIT CARD (OPTIONAL)

Authorized User's _____
First Name Middle Initial

Authorized User's _____
Last Name

Authorized User's _____
Date of Birth

Authorized User's _____
Social Security No.

155X-0606

REMINDER FOR MAILING THE APPLICATION

Be sure:

- To read the current product brochure before completing the application for insurance.

Note:

- If you were previously insured by UnitedHealthcare, you must still fully complete this application accurately. Our underwriters do not have access to UnitedHealthcare underwriting and claims files.
- Broker must be licensed with Golden Rule in state where application is signed AND state where applicant resides.
- Coverage is not available if:
  - -- any family member is currently pregnant; or
  - -- the applicant has not resided in the U.S. for the last 12 consecutive months.
- Altered applications will not be accepted.
- Any person who knowingly presents false, incomplete, or misleading information in an application for insurance may be committing insurance fraud.
- The applicant will be notified of the actions taken within 45 days after the date of the application, or be given the reason for delay.
- There is no coverage until approved in writing by Golden Rule.
- P.O. Boxes are not accepted as a Primary Resident Address.
- Applications received by Golden Rule more than 15 days after the signed date will not be accepted.

Mail the Application and Related Forms Packet to the address below.

Be sure to include the following:

- Health insurance quote.
- Initial payment check made payable to "FACT."
- P.A.C. authorization and voided check (if paying monthly).

Mail to: Golden Rule Insurance Company
HEALTH APPLICATION
Golden Rule Building
7440 Woodland Drive
Indianapolis, Indiana 46278-1719

6

Jan 27 2007 02:56:50 pm

122D-0606

Golden Rule®
A UnitedHealthcare Company

COPY

August 21, 2007

[redacted]

Identification No: [redacted]
Claimant: [redacted]
Insured: [redacted]

Dear [redacted]

Your request for benefits has been reviewed very carefully. We want to let you know the result of our review.

The Application for Coverage:

Before we can issue health insurance coverage, a customer fills out an application. We use the application to determine if we can offer coverage and rely on this information when we agree to provide coverage for a customer.

If the application is approved, a copy of it is attached and made part of the certificate. We do this so the customer can check the answers and let us know if any information is missing or incorrect. On the front of the certificate, it says "**Check the attached application.** If it is not complete or has an error, please let *us* know. An incorrect or incomplete application may cause *your* certificate to be voided and claims to be reduced or denied."

New Information From Our Review:

During our review, we requested and received medical records from [redacted] These medical records indicate that information was incorrect or missing from your application. This information would have changed the original decision to issue coverage.

According to the information we received, the answer to Question(s) 21, 23g, 23l, 25a, 25e, 28, and 32 should have been "Yes" with respect to your medical history. The application should have also contained additional medical history in response to Instruction number 33. Medical history for you should have been reported under the section of the application called "Medical History Details -- For All Applicants." A copy of the application is enclosed for your review.

The records we received indicate tha[redacted]dvised you to have an electrocardiogram for myocardial ischemia on April 11, 2002, March 1, 2004, and May 26, 2005. The records also reveal that on March 1, 2004, and May 26, 2005, you were advised to have pulmonary function tests for chronic obstructive pulmonary disease, and to check for granuloma. On May 27, 2005,

Golden Rule Insurance Company
712 Eleventh Street
Lawrenceville, Illinois 62439
www.goldenrule.com

09085412

your complete blood count was abnormal revealing an elevated red blood cell count, hemoglobin, and hematocrit. On October 25, 2006, [redacted]w you for a cough and wheezing. You were advised to stop smoking and to have pulmonary function tests as well as a computerized tomography scan of the lungs. On November 30, 2006, you were started on Chantix to help you stop smoking.

How the New Information Affects Your Coverage:

If this information had been shown correctly on your application, our underwriters would have been unable to issue your coverage.

Now that we are aware of this information, we need to take the same action we would have taken if we had been aware of this information when you applied for insurance.

Your coverage has been voided. This means it is as though it had never been approved or issued. This also means:

- We will return all premium paid;
- We will not collect any more premium;
- We will not provide coverage or pay any claims; and
- We have no liability for any current or future claims.

There may be additional information that was missing or incorrect on your application. Golden Rule reserves the right to assert any other material misstatements as reason to void your coverage. By taking this action, we are not waiving any rights under the provisions of the certificate, including, but not limited to, the preexisting conditions provision.

Premium Refund:

Enclosed is a draft for payment of $3148.56 to refund all premiums paid for your coverage. This draft also includes membership fees for Federation of American Consumers and Travelers (FACT). Any premiums you may have paid recently will be refunded to you as soon as we receive and identify them. Please note that there is a release on the back of the premium draft. By cashing the premium refund draft, you are accepting our decision to void your certificate.

Please note that if the premium refund draft is not endorsed by the payee or if the release on the back is altered, Golden Rule will not pay the draft, you will not receive the funds, and your bank may charge you penalties or fees.

Your FACT Membership:

We will not continue to collect your FACT membership dues. As we explained above, your premium refund draft includes the membership fees we collected on behalf of FACT. We have not recovered this amount from FACT. You are still a member. If you wish to remain a member, you should arrange to send your membership fee directly to FACT. Their toll free number is 1-800-USA-FACT (1-800-872-3228), or you may write to them at:

FACT
Membership Service Office
P.O. Box 104
Edwardsville, IL 62025

Summary:

Since there is no coverage, for the reasons explained above, no present or future claims will be paid.

If you have additional information you believe would change our decision, please send it to us. We will review the information and reply to you promptly.

Sincerely,

[redacted]
Claims Review

Enclosure

09/05/29 * PHONE CALL RECORDS - DATA REQUEST *

ID:[redacted] GRP: PLN:FHCA35 NAME:[redacted]
EFF:02/02/07 PD:02/02/07 STATUS:RES ISS/RES:[redacted]
CLMT: DOB: / / EFF: / / STA:[redacted]
RIDERS:
BEN RDRS:PPO025 MDBNMI PPCVRX WALPLN NETAMD STDF10
DX:
PROC:
IP: OP: DOS: NO GUAR: PREM: 4770.81 UR VEND:
PRE X: CONTEST: MED NEC: R & C:
FUND: TPA:* COLA:Y FAM:Y QUAL:N NT ACCT#:
DED: MET: COINS1: TO COINS2: TO
CALLER:[redacted] RELATE:INSURED/APPLCNT/OWNE RSN:EV
PHONE:[redacted] PLAN NAME: AGY:V1
TAKEN BY:29CJC TAKEN DATE TIME:20070829 08:41 CH:153
RETRN BY:44088 RETRN DATE TIME:20070831 13:59 CH:L49

WANTS TO KNOW WHEN HIGH BLOOD COUNT WAS.
WHY WE DROPPED WHOLE FAMILY INSTEAD OF HUSBAND.
VER PHONE
8/30/07 9:27 24887/180 - THIS REQUEST GOES TO ADJ THAT SENT LETTER PER
HC00 TO 44KTM [redacted] F/RESPONSE TO CALLER - THX
8/30/07 ROUTED TO WRONG AREA-CLAIMS. ROUTE TO THE CORRECT AREA. 004
SORRY - TO 28058 F/RESPONSE TO CALLER PLS / THX
LEFT MESSAGE -8/31/07-1:09
****
INSURED CALLED BACK IN WANTING TO KNOW WHY THIS WAS REC FOR THE WHOLE
FAMILY..... ADVISED THAT SOME WILL BE CALLING HER BACK..THNX 24776
CALLED HER BACK TOLD HER COVERAGE WAS VOIDED TO MEDICAL HISTORY NOT ON
APP--SHE SAID ELEVATED RED BLOOD COUNT--I TOLD HER THAT WAS ONLY ONE REASON
SHE ASKED ME TO READ ALL OF THEM TO HER --TOLD HER I COULD NOT DO THAT DUE
TO HIPPA LAWS=-I TOLD HER OUR REASONS WERE DETAILED IN OUR 8/21/07 LETTER
VOIDING THE COVERAGE--
SHE ASKED ME TO NOT THAT SHE WILL ACCEPT DECISION BUT FEELS LIKE WE SHOULD H
HAVE GIVEN THEM A 30 DAY NOTICE PRIOR TO VOIDING PLAN. TOLD HER I WOULD NOT
E THAT.

WELLPOINT

2003 Strategic Performance Management
Part 1A

For period of: 01/01/03 ***to:*** 12/31/03

Name: [redacted]

Job Title: **Director, Group Underwriting**

Salary Grade: **41**

Prepared by: [redacted]

Prepared by Job Title: **General Manager, Individual Services**

Date: **2/26/2004**

2003 Business Objectives & Performance Assessment
Part 2A

Business Objectives: List Business Objectives and Metrics. Rater enters weight for each objective ensuring total weight for all objectives equals 100%. At the end of the performance period, Rater reviews Business Objectives & Performance Assessment, determines ratings for each objective, and then calculates the Overall Weighted Rating for Business Objectives. **After entering Ratings and Weights, use the instructions below to calculate column totals and the Overall Weighted Rating for Business Objectives.**

5=Exceptional Performance
4=Exceeds Performance Requirements
3=Meets Performance Requirements
2=Needs Development
1=Unsatisfactory Performance
(Use this scale for objectives ratings)

No.	Objective	Metric	Weight (Number One to Hundred)	Results Achieved	Rating (Number One to Five)
1.	Meet financial and enrollment targets a) Maintain flat pmpm b) Evaluate and review underwriting guidelines, policies and procedures and workflows to meet operational metrics and maintain financial stability. c) Evaluate and refine underwriting audit process to improve quality and financial stability.		20	Reduced departmental pmpm from .7871 to .7480 while meeting/exceeding unit metrics. [redacted] has streamlined the Underwriting workflows and processes to maximize production, improve service levels, while improving accuracy as evidenced by a reduction in inventory from 14,000 to 3,000, improved turn around times from 10 days to 24 hours, decreased FTE count from 101 to 90 resulting in a savings of $900,000; reduced medical records requests from 42% to 28%, instituted electronic submission and retrieval of medical records which improved service levels from 15 days to 8 days, while reducing costs by $1,400,000. Enhanced process workflows, partnering with claims and MRU, enabling the IQRT department to review 6039 claims that resulted in a Pre-Ex savings of $1,366,503 and a Retro savings of $9,835,564.	5

Delete unused rows: Highlight Row(s), On Menu, Click "Edit" then Click "Cut"

2003 Strategic Performance Management
Section 1

WELLPOINT

For period of: 03/24/03 *to:* 12/31/03

Name: [redacted]

Social Security Number: [redacted]

Job Title: Underwriting Supervisor

Salary Grade: 37

Prepared by: [redacted]

Prepared by Job Title: Director of Underwriting & Individual Underwriting Policy

Date: January 29, 2004

2003 Objectives & Performance Assessment
Section 2

Business/Behavioral Objectives: List Business/Behavioral Objectives. Manager enters weight for each objective ensuring total weight for all objectives equals 100%. At the end of the performance period, manager reviews 2003 Objectives & Performance Assessment, determines ratings for each objective, calculates the weight for each objective, then calculates the Overall Weighted Rating for Business/Behavioral Objectives. **Space is provided for up to 15 objectives. Delete any unused row(s) using the directions at the bottom of this page.**

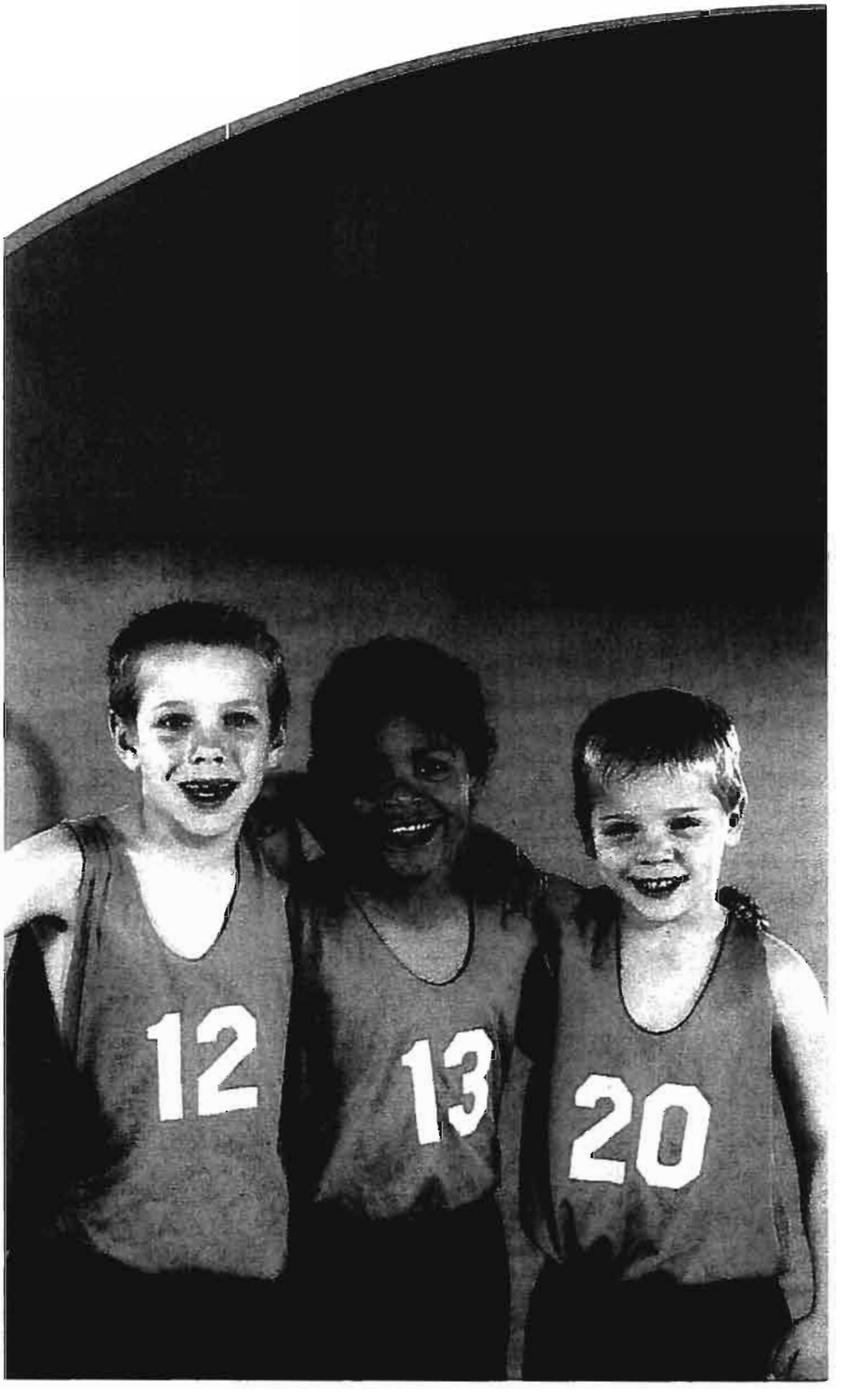
5=Exceptional Performance
4=Exceeds Performance Requirements
3=Meets Performance Requirements
2=Needs Development
1=Unsatisfactory Performance
(Use this scale for objectives ratings)

No.	Objectives	Results Achieved	Rating (Number One to Five)	Weight (Number One to Hundred)	Weighted Rating (Press "F9" key to calculate or recalculate if changes are made)
4.	Develop associate personnel to achieve desired levels of performance and leadership and increase member satisfaction.	[redacted] effectively handles all the differing viewpoints within her IQRT department. She has proven to be skillful in working through unreasonable demands. She has since developed a structure and department that is now her own. This team has achieved a high level of performance as evidenced by: • Pre-ex claims savings of $1,366,503 • Retro savings of $9,835,564 • Reduction of claims inventory of 1200 down to 500.	3	20	60.00
5.	Achieve budget goals regarding associate utilization and administrative costs.	[redacted] has achieved budget goals by monitoring and reducing her FTE's, OT FTE's and office supplies.	3	5	15.00

Delete unused rows: Highlight Row(s), On Menu, Click "Edit" then Click "Cut"

ASSURANT
Health

Your Health Insurance Reference Guide



Authorization might be required

Authorization — advanced review of planned treatment — is required before inpatient treatment, as well as outpatient surgery and other types of invasive outpatient treatment, which are listed under Utilization Review in your insurance contract.

When authorization is required, ask your health care provider to initiate the process as soon as possible prior to the beginning of treatment.

The contact number for authorization is on the back of your insurance card.

Emergency surgery or hospital admission should never be delayed for authorization. However, your health care provider should call the authorization contact number as soon as possible during/following such emergency care.

No referrals are needed to obtain health care services. Even when you need to see a specialist, you may use any health care provider you choose.

May 6, 2005

FORTIS

Solid partners, flexible solutions.

MR OTTO RADDATZ
[redacted]
[redacted] IL [redacted]

Document: [redacted]
Certificate: [redacted]
Insured: Otto Raddatz
Company: Fortis Insurance Company, NAIC: [redacted]
Your File: N/A

Fortis Health

501 West Michigan
P.O. Box 3050
Milwaukee, WI
53201-3050
Telephone
1 800 800 1212

Dear Mr. Raddatz:

This letter is in response to your inquiry dated April 25, 2005 filed with the Office of the Attorney General for the State of Illinois. You expressed a concern regarding the decision of Fortis Insurance Company to rescind your coverage under the certificate due to material misrepresentation.

We are pleased to inform you that we will be overturning our original decision to rescind your coverage. As a result, any outstanding claims will be processed for payment according to the terms, conditions, provisions and limitations of your certificate.

If you have any additional questions, please contact Customer Operations at 1-800-800-1212.

Sincerely,

[redacted]

[redacted]
Individual Medical Underwriting Correspondent

cc: Office of the Attorney General – State of Illinois

OFFICE OF THE ATTORNEY GENERAL
STATE OF ILLINOIS

Lisa Madigan
ATTORNEY GENERAL

April 26, 2005

[redacted]
Chief Executive Officer
Fortis Health
P.O. Box# 3050
Milwaukee, WI 53201-3050

Re: Otto Raddatz
[redacted]
[redacted] IL [redacted]

Dear Mr [redacted],

As Medical Director of the Office of the Illinois Attorney General, I have been asked to review the case of Mr. Otto Raddatz. Mr. Raddatz, who had been covered by State Farm for a number of years, completed an insurance application for Fortis in August 2003. On the application he indicated he had had nephrolithiasis and smoked, and he listed his physician from whom records could be obtained. His policy with Fortis began in August of 2003. In September of 2004, Mr. Raddatz unfortunately was diagnosed with non-Hodgkin's lymphoma, for which he has been undergoing treatment and is in his first partial remission. His prognosis is a matter of months if he does not go on to receive consolidation therapy. He has just finished an intense course of chemotherapy as part of that consolidation therapy that must be followed by an autologous hematopoetic cell transplantation (AHCT) within the next couple of weeks. The stem cell transplantation is necessary – indeed, life saving – as his bone marrow has intentionally been destroyed by the very aggressive chemotherapy given to treat his lymphoma. Mr. Raddatz will soon be completely pancytopenic if he does not receive a stem cell transplantation and receiving the autograft is his best chance of long term survival.

In the midst of this treatment, Mr. Raddatz received a call and a letter dated April 15, 2005 from Fortis stating his insurance is going to be rescinded as of August 2004 i.e. just prior to his diagnosis of Lymphoma. The reversal of Mr. Raddatz's insurance is being based on the fact that he did not include in his application of August 2003, the presence of two conditions that were incidentally found on a CT scan done in February of 2000 because of kidney stones: asymptomatic gallstones and a 3.5 cm abdominal aortic

aneurysm. Neither of these conditions require treatment. To a lay person, neither of these asymptomatic conditions may rise to a level of awareness when filling out, or completing, an insurance application with very general questions. Mr. Raddatz should not be expected to view these two issues as significant, nor should he be expected to even remember their presence. He is asymptomatic from these and he has never had treatment for them. Basing retroactive denial of coverage based on this type of information is stretching the interpretation of insurance code beyond its intended boundary.

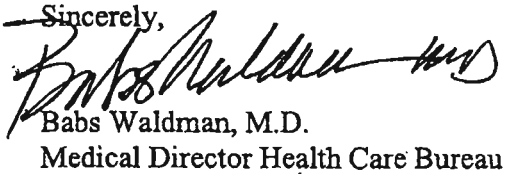
I find the behavior on the part of Fortis Health to be extremely troubling if not unethical. Clearly, there is no justification for rescinding this gentleman's insurance beyond avoiding the cost of his future treatment. The findings for which Fortis is rescinding/terminating Mr. Raddatz's coverage have absolutely nothing to do with his compelling diagnosis. To do rescind/terminate his policy at this point is not only devastating but probably fatal for Mr. Raddatz. In effect, by rescinding/terminating his coverage you are telling a dying patient that he cannot have the only treatment that can potentially save his life. Indeed, now that he is without insurance, the treating hospital will not proceed with the transplant unless Mr. Raddatz pays upfront.

Unfortunately, this is not the only complaint of this nature we have received. There seems to be a very distinct pattern in which Fortis rescinds insurance policies once claims have been made. The reasons for terminating insurance, such as Mr. Raddatz's, are not reasonably related to the diagnosis for which the claims are made. Often the conditions do not impact the consumer's health, nor might be expected to be thought of as significant by the consumer. Many conditions could have been dealt with by use of riders or exclusions. In the case of Mr. Raddatz there is life-threatening urgency. It is our hope that you will reinstate Mr. Raddatz's coverage and allow him to receive this life-saving treatment.

We expect a reversal of this most disturbing decision and need to hear ASAP as Mr. Raddatz needs to have this treatment within the next two to three weeks.

Dr. Babs H. Waldman, M.D.
Medical Director
Health Care Bureau
Office of the Illinois Attorney General
100 W. Randolph Street, 12th Floor
Chicago, IL 60601

Sincerely,



Babs Waldman, M.D.
Medical Director Health Care Bureau
[redacted] Fax [redacted]

Cc. Otto Raddatz
[redacted]

From: [redacted]
Sent: Monday, January 22, 2007 3:37 PM
To: [redacted]
Subject: research and fast response needed!
Importance: High

I just received a call from [redacted] with [redacted] Medical Oncology Head and Neck. She wanted to give me a heads-up on [redacted], who we rescinded on Jan[redacted], 2007 letter dated January[redacted], 2007. Per [redacted] because he no longer has insurance the surgeons scheduled to operate on his Stage III cancer this week have cancelled specifically due to his lack of insurance. [redacted] states there is a lawyer letter from [redacted] here as well as a retraction of medical record from [redacted] physician who counseled him regarding his COPD. Neither letter have I seen.

Have these letters been received by Appeals?

[redacted] CIFI
[redacted] fax

01/23/2007