

FREEDOM LIFE INSURANCE COMPANY OF AMERICA

APP

3100 Burnett Plaza, 801 Cherry Street, Unit 33, Fort Worth, Texas 76102

APPLICATION FOR ASSOCIATION GROUP HEALTH INSURANCE

WARNING: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. BEFORE YOU ENROLL IN THIS PLAN, READ ALL OF THE RULES VERY CAREFULLY AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

Application for New Coverage Add-On Benefit Change Exchange For Certificate/Policy #: _____

SECTION 1: APPLICANT(S) INFORMATION

Applicant's Last Name	First	Middle	Sex	Date of Birth	Age	Height	Weight
(a)				/ /			
Social Security Number	Birthplace		Marital Status		Telephone		
			<input type="checkbox"/> Single <input type="checkbox"/> Married		Home ()	Work ()	Cell ()
Street Address	City		County	State	Zip		
Employer Name		Phone#	Occupation		Duties		

Member(s) of Family to be Covered Attach another page signed and dated by the applicant, for additional dependents.

Last Name	First	M.I.	Relation	Sex	Birth date	Age	Ht.	Wt.	Social Security No.	Birthplace
(b)			Spouse							
(c)			Dependent							
(d)			Dependent							
(e)			Dependent							
(f)			Dependent							

Spouse's Employer (If To Be Covered)	Occupation	Duties

Applicant's email address _____ May the Company communicate with You by email? Yes No

SECTION 2: OTHER COVERAGE INFORMATION

1. Subject to applicable State and Federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all health insurance carriers to consider accepting "Eligible Individuals" who apply for certain coverage in the Individual Health Insurance Market. Please provide a Certificate of Health Plan Coverage, if available. The following questions will assist the Company in determining the status of eligibility:
 - a) Has any applicant or dependent had health plan coverage in effect for the past 18 months with no significant breaks in coverage of 63 days or more? If "Yes," which applicant or dependent? _____ Date Issued _____ Yes No
 - b) Was the most recent coverage under a Group Health Plan (employer provided), Governmental Plan or Church Plan? Yes No
If "Yes," which applicant or dependent? _____
 - c) Was the most recent coverage terminated for nonpayment of premiums or fraud? Yes No
 - d) Is any applicant or dependent eligible for coverage under a group health plan, Medicare or Medicaid? Yes No
If "Yes," which applicant or dependent? _____
 - e) Does any applicant or dependent currently have other health insurance coverage? Yes No
If "Yes," which applicant or dependent? _____
 - f) Is any applicant or dependent eligible for any continuation of coverage under COBRA or State Continuation Plan? Yes No
If "Yes," has such applicant or dependents both elected and exhausted such continuation of coverage? Yes No
If "Yes," which applicant or dependent? _____ Date Issued _____
2. Have You or any proposed applicant listed ever been declined, restricted, rated-up or postponed for any kind of personal insurance, or in the past 18 months filed a claim for disability, or receiving benefits from Social Security or Workers' Compensation? Yes No
If yes, provide details _____

3. Please list all other types of health, medical expense, or life coverage You currently have in force or for which You are currently applying with other carriers. This includes all individual or group insurance, any health maintenance organization (HMO), Preferred Provider Plan (PPO), Medicare, Medicaid, Veterans Insurance or other governmental insurance assistance program. (Attach separate sheet if necessary)

Name of Company & Policy #	Life Face Amount	Hospital Benefit		Major Medical		Coverage Period	
		Room & Board	Misc	Maximum	Deductible	Effective Date	Term Date

4. Will the coverage for which You are applying with Our Company replace Your existing coverage? Yes No
You should not cancel or reduce any of Your current coverage until You have received, reviewed and accepted any coverage from the Company that may be issued by the home office of the Company in response to this Application. Any coverage issued by the Company will be contained in a Certificate of coverage issued to You under the association group policy.

SECTION 3: COVERAGE INFORMATION

Has any proposed applicant(s) listed now or during the past 12 months used any form of tobacco, including cigarettes, cigars, pipes, chewing tobacco or snuff? Yes No If yes, which applicant(s) _____

Method of Payment <input type="checkbox"/> Bank Draft <input type="checkbox"/> Direct Bill	Mode of Payment <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annually
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HSA QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN

INDIVIDUAL PLAN		LIFETIME CERTIFICATE MAXIMUM	
<input type="checkbox"/> 100/80% Coinsurance Percentage In-Network/Out-of-Network Deductibles <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,700 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$5,000	<input type="checkbox"/> \$2,000,000 <input type="checkbox"/> \$5,000,000	Base Premium	\$ _____
<input type="checkbox"/> 80/60% Coinsurance Percentage In-Network/Out-of-Network Deductibles <input type="checkbox"/> \$1,200 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,700 <input type="checkbox"/> \$3,500	Rate-up _____ % for _____	Rate-up _____ % for _____	\$ _____
<input type="checkbox"/> 50/50% Coinsurance Percentage In-Network/Out-of-Network Deductibles <input type="checkbox"/> \$1,200 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,700 <input type="checkbox"/> \$3,500	Options: <input type="checkbox"/> Maternity Rider (only available on Family Plan Deductibles of \$4,000 or more) \$ _____ <input type="checkbox"/> Optional Rider _____ \$ _____		
FAMILY PLAN		Area Rate Factor _____	
<input type="checkbox"/> 100/80% Coinsurance Percentage In-Network/Out-of-Network Deductibles <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,400 <input type="checkbox"/> \$7,000 <input type="checkbox"/> \$10,000	Policy Administration Fee \$ _____		
<input type="checkbox"/> 80/60% Coinsurance Percentage In-Network/Out-of-Network Deductibles <input type="checkbox"/> \$2,400 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,400 <input type="checkbox"/> \$7,000	Total Insurance Amount \$ _____		
<input type="checkbox"/> 50/50% Coinsurance Percentage In-Network/Out-of-Network Deductibles <input type="checkbox"/> \$2,400 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,400 <input type="checkbox"/> \$7,000	Consumers Independent Association Initiation Fee \$ _____ Membership Fee \$ _____		
	Total Association Amount \$ _____		
	Total Amount Received \$ _____		

Effective Date Request: Please choose one of the following. The date requested cannot be before the application date and no more than 60 days after the application date, and may not fall on the 29th, 30th, or 31st of the month. If no effective date is requested, the Effective Date will be the date of the underwriting decision. This effective date request does not guarantee that the underwriting will be completed before the requested date, and thus may not be awarded.

<input type="checkbox"/> Specific Date / /	<input type="checkbox"/> On the next _____ (except 29 th , 30 th , or 31 st) of the month after underwriting decision.	<input type="checkbox"/> Date of Underwriting Decision
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SECTION 4: BENEFICIARY DESIGNATION

Your Beneficiary: _____

Your Spouse's Beneficiary: _____

Your Child's (ren's) Beneficiary: _____

SECTION 5: MEDICAL HISTORY (CIRCLE CONDITIONS ANSWERED "YES")

<p>1 Have You or any applicant family member listed, ever had or been treated for any of the following:</p> <p>a) Tuberculosis, Emphysema, Chronic Obstructive Pulmonary Disease, Asthma, Hay Fever, Sinusitis, Bronchitis, Difficulty Breathing, Sleep Apnea, Cystic Fibrosis or any Disease or Disorder of the Lungs, Bronchi, Sinuses, or Respiratory System? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) High or Low Blood Pressure, Hypertension, Stroke, Heart Murmur, Mitral Valve Prolapse, Heart Attack, Palpitations, Phlebitis, Varicose Veins, Aneurysm, Rheumatic Fever, or any Disease or Disorder of the Heart, Circulatory System, Veins or Arteries? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c) Anemia, Hemophilia, Disease or Disorder of the Blood, Platelets, or any other Bleeding or Blood Forming Disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d) Ulcers, Colitis, Inflammation of the Intestines, Chronic Diarrhea, Hernia, Hemorrhoids, Disease or Disorder of Stomach, Esophagus, Intestines, Rectum, or Colon? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e) Hepatitis, Cirrhosis, Jaundice, Gallstones, or any disease or disorder of the Gall Bladder, Liver, or Biliary Tract? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f) Kidney Stones, Urinary Tract Infections, Urinary Incontinence, Prostatitis, or any Disease or Disorder of the Kidneys, Bladder, Urethra, Prostate, or Urinary System? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>g) Diabetes, or sugar intolerance, Pancreatitis or any disease or disorder of the Pancreas? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>h) Graves' Disease, Goiter, or any Disease or Disorder of the Thyroid, Pituitary, Adrenal or any other gland(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>i) Parkinson's Disease, Multiple Sclerosis, Muscular Dystrophy, Lou Gehrig's Disease ALS, or any other Degenerative Neuromuscular Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>j) Lupus or Lyme Disease or any Disease or Disorder of the Connective Tissue? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>k) Rheumatism, Osteoarthritis, Rheumatoid Arthritis, Gout, Fibromyalgia, or any Disease or Disorder of the Bones, Joints, Tendons, Ligaments or Muscles? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>l) Sprain/strain of the Neck, Back or any portion of the Spine, Disc Disorder or Disease, or any other Disease or Disorder of the Back or Spine, including adjustments or spinal manipulations? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>m) Convulsions, Epilepsy, Seizures, Recurrent Headaches, Migraine(s), Depression, Anxiety, or Mental Nervous Disorder, Paralysis, Paraplegia, or Quadriplegia, or any Disease or Disorder of the Brain or Nervous System? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>n) Senility Disorder, Organic Brain Disease, Alzheimer's Disease, or any other form of Dementia? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>o) Bulimia or Anorexia, or any other form of Eating Disorder, or surgery for weight control? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>p) Mental Retardation, Learning/Behavioral Disorder, Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder, or any other Mental, Emotional or Developmental Disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>q) Psoriasis, Eczema, Keloidosis, or any other Disease or Disorder of the Skin? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>r) Glaucoma, Cataract, Blindness, or any Disease or Disorder of the Eyes? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>s) Otitis Media, Hearing Loss, Cochlear Implants, or any Disease or Disorder of the Ears? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>t) Cancer, Tumor, Cyst, or any form of Growth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>u) Endometriosis, Pelvic Pain, Menstruation Disorder, Abnormal Pap Test, Cyst, Fibroid Tumors, or any Disease or Disorder of the Breast, Uterus, Tubes, or Male/Female Reproductive System? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>v) Syphilis, Gonorrhea, Genital Herpes, or any form of Venereal or Sexually Transmitted Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2 Has any proposed applicant listed received consultation or advice, screening, testing, or counseling for infertility, impotence, including in-vitro fertilization, artificial insemination, or surrogacy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3 Has any proposed applicant listed ever been treated for hormone imbalance or oral contraceptive reaction of any kind? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4 Has any proposed applicant listed ever had a Cesarean Section, miscarried, had an abortion, or had a premature delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5 Is any proposed applicant listed currently pregnant, or expecting a child with anyone, whether or not listed on this application? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6 Has any proposed applicant listed tested positive for the presence of the HIV infection, or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7 Has any proposed applicant listed had or considering any cosmetic or reconstructive surgery, breast augmentation surgery, has or had any congenital birth defects or bodily deformity, or any monitoring device, pacemaker, implants or internal fixations (i.e. pins, plates, screws, etc)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8 During the past five years, has any proposed applicant listed gone to a doctor, chiropractor, or any health care professional for diagnosis, advice, treatment, checkup or consultation, or been confined to a hospital, clinic, sanitarium, or other facility? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Give full details for all questions in Section 5 answered "Yes."

Applicant	Question #	Condition/Illness/Disorder	Treatment Dates		Recovered?	Days Hospitalized/ Surgery Performed	Name/Address/Phone No. Doctor or Hospital
			From	To			

SECTION 6: GENERAL INFORMATION

Provide details below for any question that is answered "Yes" for You or any member listed:

<p>1 Has any applicant listed ever had any amputation(s), prosthesis or braces, or been advised to use a walking aid, wheelchair, or any other device or equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2 Has any applicant listed ever used drugs or narcotics such as heroin, morphine, marijuana, cocaine, barbiturates, amphetamines, hallucinogenic drugs, or any other drugs or narcotics? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3 Has any applicant listed ever been advised to have treatment or been treated for alcohol or drug abuse, been a member of any alcohol or drug support group, or been given counseling or directive to seek treatment for use or abuse of alcohol or drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>4 Has any applicant listed ever had three or more moving violations, or a DWI or DUI citation, or had their driver's license suspended or revoked, or been convicted of a felony or currently on probation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5 Has any applicant listed ever engaged in or intend to engage in any hazardous avocation or sport such as scuba diving, sky diving, hang gliding, ATV driving, rodeo, vehicle racing or other hazardous avocation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6 In the past 5 years, has any applicant made or is any applicant contemplating making flights as a pilot, student pilot or crew member? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7 Are all applicants listed U.S. Citizens or if not U.S. Citizens, have all applicants been issued a Permanent Residence status? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8 Has any applicant traveled outside the U.S. for more than 30 days in the past two years, or does any applicant plan to travel outside the U.S. for more than 30 days during the next two years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Provide full details for all questions in Section 6 answered "Yes".

Applicant	Question #	Details

List below all Prescription Drugs that any applicant is currently taking or has been taken within the last 12 months?

Applicant	Medication/Prescription and Dosage	Diagnosis Illness or Condition for prescription	Date Prescribed	Date discontinued and reason	Name/Address/Phone# Doctor or Hospital

Please give Name, Address, and Phone No. for any Doctor with current medical records, if not listed above. Include the date last seen and reason.

APPLICANT'S STATEMENTS

It is very important to disclose your complete health history and fully answer all the questions on the Application for Insurance.

The agent signing below contacted me about applying for insurance with your Company. He/She provided me with a brochure of the coverage I am applying for, and explained to me the benefits, waiting periods, limitations for pre-existing conditions, and all other limitations and exclusions in the group Certificate. I have read the brochure and understand it. I understand that the brochure is only a summary of the coverage plan applied for and is not the Certificate. The agent discussed each and every question in the application with me and I have fully and truthfully answered each question. I understand and acknowledge that the Company will rely on these answers in determining whether or not coverage is approved and issued for me, or any other applicant. I understand and acknowledge that the agent cannot change, alter or amend any information requirement of the Company. I also understand and acknowledge that the agent is not an officer or employee of the Company and cannot change, alter or amend the group policy, the application, or the Certificate of insurance. I further understand that the agent has no authority to make any representations about the conditions under which the Company will or will not issue a Certificate. However, we have discussed, and I understand, the circumstances under which an exclusion rider (Certificate Amendment) may be attached to the Certificate, if issued. Please initial below signifying your review of and agreement with the previous statements.

Applicant's Initials Agent's Initials

AUTHORIZATION TO HONOR CHECKS DRAWN BY FREEDOM LIFE INSURANCE COMPANY OF AMERICA

As a convenience to me, I hereby request, authorize, and instruct Freedom Life Insurance Company of America, Fort Worth, Texas, to initiate charges (debits) on my bank and checking account listed below on or about the renewal date of any Certificate issued. The Company may revoke payment under this method if any payment is dishonored. I understand that I can request that the Company initiate an alternative payment mode acceptable to the Company in order to keep the coverage paid current. I understand that the authority of the Company to draft my bank and checking account shall remain in effect until I notify, and the Company receives, my request for an alternative payment mode acceptable to the company in order to keep the coverage paid current.

I have read and understand and agree to the Applicant's Statements and Authorization made above.

Applicant's Signature

Date

Printed Name of Account Holder if different from Applicant

ABA Account #

Account Holder's Signature if different than Applicant

Attached Voided Check Here

AGENT'S REPORT

- | | | |
|---|------------------------------|-----------------------------|
| A. How long have you known the proposed insured? _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| B. Are you related to the proposed insured? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| C. Was this application taken in person? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| D. Do you know anything not disclosed in writing in the Application for Insurance which might affect the underwriting of this risk? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| E. Is there another application by the proposed insured pending or being submitted to any other life or health insurance company? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| F. Has any proposed insured applied elsewhere for any insurance coverage within the past six months? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| G. Do you have knowledge or reason to believe that replacement of existing insurance may be involved? If yes, submit the appropriate replacement forms. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Additional Remarks:

I certify I have personally asked each question on the application and accurately recorded all information given by the proposed insured. I represent and warrant that I have recorded the entirety of the proposed insured's health history as the same was represented to me by the proposed insured. I represent and warrant that I have fully explained the coverage available to the proposed insured including all limitations, exclusions and waiting periods. I further certify that my statements in this Agent's Report are correct to the best of my knowledge.

Print Agent's Name

Agent's Signature

Agent's Number

Date



Credit Suisse First Boston Private Equity

3100 Burnett Plaza • 801 Cherry Street, Unit 33 • Fort Worth, Texas 76102

This notice is provided to you under the requirements of federal legislation entitled the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This is a periodic notice that you will continue to receive while you are insured with our Company. This notice **does not** affect your coverage in any way. **No action is required of you.**

Effective date of this notice: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

SUMMARY

In order to provide you with benefits, Freedom Life Insurance Company of America will receive personal information about your health, from you, your physicians, hospitals, and others who provide you with health care services. We are required to keep this information confidential. This notice of our privacy practices is intended to inform you of the ways we may use your information and the occasions on which we may disclose this information to others.

Occasionally, we may use members' information when providing treatment. We use members' health information to provide benefits. We disclose members' information to health care providers to assist them to provide you with treatment or to help them receive payment, we may disclose information to other insurance companies as necessary to receive payment, we may use the information within our organization to evaluate quality and improve health care operations, and we may make other uses and disclosures of members' information as required by law or as permitted by Freedom Life Insurance Company of America policies.

KINDS OF INFORMATION THAT THIS NOTICE APPLIES TO

This notice applies to any information in our possession that would allow someone to identify you and learn something about your health. It does not apply to information that contains nothing that could reasonably be used to identify you.

WHO MUST ABIDE BY THIS NOTICE

- Freedom Life Insurance Company of America.
- All employees, staff, and other personnel whose work is under the direct control of Freedom Life Insurance Company of America.

The people and organizations to which this notice applies (referred to as "we," "our," and "us") have agreed to abide by its terms. We may share your information with each other for purposes of treatment, and as necessary for payment and operations activities as described below.

OUR LEGAL DUTIES

- We are required by law to maintain the privacy of your health information.
- We are required to provide this notice of our privacy practices and legal duties regarding health information to anyone who asks for it.
- We are required to abide by the terms of this notice until we officially adopt a new notice.

HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION.

We may use your health information, or disclose it to others, for a number of different reasons. This notice describes these reasons. For each reason, we have written a brief explanation. We also provide some examples. These examples do not include all of the specific ways we may use or disclose your information. But any time we use your information, or disclose it to someone else, it will fit one of the reasons listed here.

1. Treatment. This means that our employees, staff, and others whose work is under our direct control, may read your health information to learn about your medical condition and use it to help you make decisions about your care. We will also disclose your information to others to provide you with medical treatment or services.

2. Payment. We will use your health information, and disclose it to others, as necessary to make payment for the health care services you receive. For instance, an employee in our claim processing department may use your health information to pay your claims. And we may send information about you and your claim payments to the doctor or hospital that provided you with the health care services. We will also send you information about claims we pay and claims we do not pay (called an "explanation of benefits"). The explanation of benefits will include information about claims we receive for the insured and each dependent who are enrolled together under a single contract or identification number. Under certain circumstances, you may receive this information confidentially; see the "Confidential Communication" section in this notice. We may also disclose some of your health information to companies with whom we contract for payment-related services. We will not use or disclose more information for payment purposes than is necessary.

3. Health Care Operations. We may use your health information for activities that are necessary to operate this organization. This includes reading your health information to review the performance of our staff. We may also use your information and the information of other members to plan what services we need to provide, expand, or reduce. We may disclose your health information as necessary to others who we contract with to provide administrative services. This includes our lawyers, auditors, accreditation services, and consultants, for instance.

4. Legal Requirement to Disclose Information. We will disclose your information when we are required by law to do so. This includes reporting information to government agencies that have legal responsibility to monitor the health care system. For instance, we may be required to disclose your health information, and the information of others, if we are audited by the state insurance department. We will also disclose your health information when we are required to do so by a court order or other judicial or administrative process.

5. Public Health Activities. We will disclose your health information when required to do so for public health purposes. This includes reporting certain diseases, births, deaths, and reactions to certain medications. It may also include notifying people who have been exposed to a disease.

6. To Report Abuse. We may disclose your health information when the information relates to a victim of abuse, neglect or domestic violence. We will make this report only in accordance with laws that require or allow such reporting, or with your permission.

7. Law Enforcement. We may disclose your health information for law enforcement purposes. This includes providing information to help locate a suspect, fugitive, material witness or missing person, or in connection with suspected criminal activity. We must also disclose your health information to a federal agency investigating our compliance with federal privacy regulations.

8. Specialized Purposes. We may disclose the health information of members of the armed forces as authorized by military command authorities. We may disclose your health information for a number of other specialized purposes. We will only disclose as much information as is necessary for the purpose. For instance, we may disclose your information to coroners, medical examiners and funeral directors; to organ procurement organizations (for organ, eye, or tissue donation); or for national security, intelligence, and protection of the president. We also may disclose health information about an inmate to a correctional institution or to law enforcement officials, to provide the inmate with health care, to protect the health and safety of the inmate and others, and for the safety, administration, and maintenance of the correctional institution. We may also disclose your health information to your employer for purposes or workers' compensation and work site safety laws (OSHA, for instance).

9. To Avert a Serious Threat. We may disclose your health information if we decide that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.

10. Family and Friends. We may disclose your health information to a member of your family or to someone else who is involved in your medical care or payment for care. This may include telling a family member about the status of a claim, or what benefits you are eligible to receive. In the event of a disaster, we may provide information about you to a disaster relief organization so they can notify your family of your condition and location. We will not disclose your information to family or friends if you object.

11. Information to Members. We may use your health information to provide you with additional information. This may include sending appointment reminders to your address. This may also include giving you information about treatment options, alternative setting for care, or other health-related services that may be eligible under your plan.

12. Health Benefits Information. If your enrollment in your health plan is sponsored by your employer, your health information may be disclosed to your employer, as necessary for the administration of your employer's health benefit program for employees. Employers may receive this information only for purpose of administering their employee group health plans, and must have special rules to prevent the misuse of your information for other purposes.

YOUR RIGHTS

1. Authorization. We may use or disclose your health information for any purpose that is listed in this notice without your written authorization. We will not use or disclose your health information for any other reason without your authorization. If you authorize us to use or disclose your health information, you have the right to revoke the authorization at any time. For information about how to authorize us to use or disclose your health information, or about how to revoke an authorization, contact the person listed under "Whom to Contact" at the end of this notice. You may not revoke an authorization for us to use and disclose your information to the extent that we have taken action in reliance on the authorization. If the authorization is to permit disclosure of your information to an insurance company, as a condition of obtaining coverage, other law may allow the insurer to continue to use your information to contest claims or your coverage, even after you have revoked the authorization.

2. Request Restrictions. You have the right to ask us to restrict how we use or disclose your health information. We will consider your request. But we are not required to agree. If we do agree, we will comply with the request unless the information is needed to provide you with emergency treatment. We cannot agree to restrict disclosures that are required by law.

3. Confidential Communication. If you believe that the disclosure of certain information could endanger you, you have the right to ask us to communicate with you at a special address or by a special means. For example, you may ask us to send explanations of benefits that contain your health information to a different address rather than to your home. Or you may ask us to speak to you personally on the telephone rather than sending your health information by mail. We will agree to any reasonable request.

4. Inspect and Receive a Copy of Health Information. You have the right to inspect the health information about you that we have in our records, and to receive a copy of it. This right is limited to information about you that is kept in records that are used to make decisions about you. For instance, this includes claim and enrollment records. If you want to review or receive a copy of these records, you must make the request in writing. We may charge a fee for the cost of copying and mailing the records. To ask to inspect your records, or to receive a copy, contact the person listed under "Whom to Contact" at the end of this notice. We will respond to your request within 30 days. We may deny you access to certain information. If we do, we will give you the reason, in writing. We will also explain how you may appeal the decision.

5. Amend Health Information. You have the right to ask us to amend health information about you which you believe is not correct, or not complete. You must make this request in writing, and give us the reason you believe the information is not correct or complete. We will respond to your request in writing within 30 days. We may deny your request if we did not create the information, if it is not part of the records we use to make decisions about you, if the information is something you would not be permitted to inspect or copy, or if it is complete and accurate.

6. Accounting of Disclosures. You have a right to receive an accounting of certain disclosures of your information to others. This accounting will list the times we have given your health information to others. The list will include dates of the disclosures, the name of the people or organizations to whom the information was disclosed, a description of the information, and the reason. We will provide the first list of disclosures you request at no charge. We may charge you for any additional lists you request during the following 12 months. You must tell us the time period you want the list to cover. You may not request a time period longer than six years. We cannot include disclosures made before April 14, 2003. Disclosures for the following reasons will not be included on the list: disclosures for treatment, payment, or health care operations; disclosures for national security purposes; disclosures to correctional or law enforcement personnel; disclosures that you have authorized; and disclosures made directly to you.

7. Paper Copy of this Privacy Notice. You have a right to receive a paper copy of this notice. If you have received this notice electronically, you may receive a paper copy by contacting the person listed under "Whom to Contact" at the end of this notice.

8. Complaints. You have a right to complain about our privacy practices, if you think your privacy has been violated. You may file your complaint with the person listed under "Whom to Contact" at the end of this notice. You may also file a complaint directly with the Secretary of the U.S. Department of Health and Human Services, at the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S. W., Room 509F HHH Bldg., Washington, D.C. 20201. All complaints must be in writing. We will not take any retaliation against you if you file a complaint.

OUR RIGHT TO CHANGE THIS NOTICE

We reserve the right to change our privacy practices, as described in this notice, at any time. We reserve the right to apply these changes to any health information which we already have, as well as to health information we receive in the future. Before we make any change in the privacy practices described in this notice, we will write a new notice that includes the change. The new notice will include an effective date. We will mail the new notice to all subscribers within 60 days of the effective date.

WHOM TO CONTACT.

Contact the person listed below:

- For more information about this notice, or
- For more information about our privacy policies, or
- If you want to exercise any of your rights, as listed on this notice, or
- If you want to request a copy of our current notice of privacy practices.

Privacy Office
3100 Burnett Plaza
801 Cherry Street, Unit 33
Fort Worth, Texas 76102
1-800-387-9027

This notice is also available by e-mail. Contact the person named above, or send an e-mail to: flica@insurance-privacy.com

FREEDOM LIFE INSURANCE COMPANY OF AMERICA

(Hereinafter referred to as the "Company")

3100 Burnett Plaza • 801 Cherry Street, Unit 33 • Fort Worth, Texas 76102
1-800-387-9027

Initial RECEIPT

Date _____

Received of _____

Address _____

The initial payment of \$ _____ has been conditionally accepted by the Company.

Being the initial _____ months payment on the enrollment application for a Certificate to be issued by the Company, in Fort Worth, Texas. I understand that the insurance applied for shall be subject to the provisions and conditions of the Policy, and that the coverage shall not be effective until a Certificate of Coverage or Policy has been actually issued and delivered to the Insured, with the first premium paid while the health of all persons named in the enrollment application remains as stated in the enrollment application.

This receipt shall be void if given for a check or draft, which is not honored on presentation. All checks must be made payable to the Company: DO NOT make check payable to the agent or leave the payee blank.

Agent Signature _____ Agent Number _____

If the application is not acknowledged or Certificate of Coverage received within forty (40) days, notify the Company immediately at 1-800-387-9027.

TELEPHONE CONTACT AUTHORIZATION AND AGREEMENT: To expedite the processing of my application for insurance, I authorize the Company to contact me by telephone to verify information recorded on my application for insurance. I understand and agree that the insurance coverage may be issued to me based solely and entirely upon the information provided in the application for insurance and by any telephone verifications. Should I be contacted by telephone, I authorize and consent to the recording of the conversation and I agree that such recording can be made a part of my application for insurance. I further represent that I will fully and truthfully answer all questions or inquiries made of me during any telephone verification.

Please allow two weeks processing time. If you have not been contacted by the Home Office after that time, please call our toll free number 1-800-387-9027. If we are unable to take your call, please leave your name, phone number with area code, state of residence, application number if known, and best time to call back.

NOTICE: This is to inform you as part of our procedure for processing your application an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of the investigation.

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may however, make a brief report thereof to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (866) 692-6901 (TTY (866) 346-3642 for hearing impaired).

The Company or its reinsurer may also release information in its file to other life insurance companies to whom you apply for life or health insurance, or to whom a claim of benefits may be submitted.

NOTICE: You are not required to disclose your Social Security Number, but we request it only to aid in our administrative procedures.

(Leave with Applicant)

Authorization to Use and Disclose Protected Health Information

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has records or knowledge of me, or any member of my family who is to be insured, to give (disclose) to Freedom Life Insurance Company of America or its reinsurer any such information. To facilitate rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give all such records or knowledge to any agency employed by Freedom Life Insurance Company of America to collect and transmit such information. I authorize Freedom Life Insurance Company of America to use such information in determinations regarding enrollment, underwriting, eligibility of benefits, or any other healthcare operations related to the consumer as a prospective insured or as an insured with Freedom Life Insurance Company of America. A photographic or electronic copy of this authorization shall be as valid as the original. This authorization shall be valid for two years from the date signed. I have received a copy of the Freedom Life Insurance Company of America Notice of Privacy Practices.

Print Applicant's Name	Applicant's Signature	Date
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Print Spouse's Name	Spouse's Signature	Date
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Notice to Consumer

You may revoke this authorization at any time. To revoke this authorization, send a written statement to the Company Privacy Official, 3100 Burnett Plaza, 801 Cherry Street, Unit 33, Fort Worth, Texas, 76102. The statement must identify this authorization by referring to the date it was signed. The statement must include the date on which this authorization is no longer in force.

If you revoke this authorization, we may still use and disclose the information for the purposes listed, if we have already taken action in reliance on the authorization. Since this authorization is to permit disclosure of information to an insurance company, in order for you to obtain insurance coverage, the insurance company may still have the legal right to use the information to contest a claim or to contest your coverage.

You may refuse to sign this authorization. You do not need to sign this authorization to receive health care services EXCEPT in the following circumstances:

- If the only purpose for providing you with a service is to obtain health information to disclose to someone else, then you must authorize that disclosure in order to receive the service.
- If the services are related to research, you may be required to authorize the use or disclosure of your health information for the research. This applies only to health information related to the research services. The use and disclosure of your information will be limited to what is necessary for the research. If you do not authorize the use and disclosure of your information for the research, you may not be eligible to receive the services.

You do not have to sign this authorization to receive payment, to enroll in the plan, or to be eligible for benefits, except:

- If this authorization is sought for the purpose of determining your eligibility for benefits or is necessary for any other healthcare operations, then you must authorize Freedom Life Insurance Company of America to obtain the necessary information or the benefits, enrollment, or provision of service through other healthcare operations may be denied.
- If this authorization is sought for the purpose of underwriting or risk rating determinations, then you must authorize Freedom Life Insurance Company of America to obtain the necessary information or benefits or enrollment may be denied.
- Under Federal law, you do not have to authorize us to receive the private notes from counseling sessions, that are kept by a mental health professional, as a condition of payment, enrollment in a health plan, or eligibility for benefits.

A person or organization that receives your information because of this authorization may have the legal right to disclose this information to other people or organizations without your knowledge or consent.