A member of Zurich Financial Services Group

Rated A (Excellent) by A.M. Best Company (A.M. Best is an independent analyst of the insurance industry; rating based on financial and operating performance)

presents

Sponsored By
Consumer Benefits of America
Consumer Benefits of America's mission is to promote consumer awareness in the marketplace. The association membership includes benefits which are designed to enhance the mission and provides members with the advantage of "group buying".

The American Select

$2,000,000 Maximum Benefit

Association Group Major Medical Insurance

The Perfect Solution For:

- College Students/New Grads
- Part-Time/Temporary Employees
- Anyone Between Jobs/COBRA
- New Employee Waiting Period
- Dependent Child Coverage
- Anyone Waiting To Be Covered By Other Insurance

Affordable Benefit Features:

- Choice of Any Physician or Hospital
- Coverage Period up to 6 Months
- Convenient Monthly Payment Option, or SAVE 20% with Prepayment Option of 6 Months

Who Is Eligible For Coverage?

Members or members' dependents are eligible for coverage if the following guidelines are met:

- Member is a dues-paying member of Consumer Benefits of America
- Adults under age 60; and
- Dependent children from 15 days to age 19 (25 if full-time student)

For all eligible persons:

- Who have not received consultation or treatment within the last five years for any conditions identified on the application
- Who are not pregnant or an expectant parent
- Who have no other hospital or medical coverage in force
- Who possess a valid Social Security number; or are foreign citizens that have resided in the U.S. for the last six months

Monthly Rate Calculation Worksheet

1. Choose your deductible: ❑ $250 ❑ $500 ❑ $1000 ❑ $2500 ❑ $5000
2. Determine age and gender of proposed insured(s), select, enter and add premium for each insured(s)
   Applicant ___________
   Spouse ___________
   When writing children alone (no adult applying), the youngest child will be the primary applicant. Use the appropriate deductible for a 0-29 male rate. For additional children applying, charge at "Dependent Child(ren) Rate".
   Child(ren) ___________
   Total ___________
3. Determine the New Business Trend Factor (from table) x ___________
   Total Trend Premium ___________
4. Determine your area factor from the table and multiply the total by your factor x ___________
   80/20 Total Medical Premium ___________
5. *If you elect the 50/50 plan,* multiply the total medical premium from Step 4 by .7 x .7
   50/50 Total Medical Premium ___________
6. If prepaying for 6 months, multiply the total medical premium from Step 4 or Step 5, as applicable, by .8 x .8
   Total Prepaid Medical Premium ___________
7. Add the monthly administration fee + $14.00
8. Add the monthly CBA dues + $3.00
   Initial Monthly Remittance $ ___________
9. If prepaying for 6 months, multiply the Initial Monthly Remittance by 6 ___________
   Total Initial Prepaid Remittance $___________

MAIL your completed application along with your Total Initial Remittance payment to: **NIA Corporation, PO Box 150832, Denver, CO 80215** *or*

If you are paying by credit card, you can **FAX** your application to **303-232-4758** (faxed applications must be legible)

Monthly Premium Rate Chart

80/20 coinsurance. Rates effective 10/03.

Age Band	1 Month to 6 Months* Deductible Choice				
Male	*$250*	*$500*	*$1000*	*$2500*	*$5000*
0-29	59	46	42	39	36
30-34	61	48	43	40	36
35-39	77	61	55	51	47
40-44	100	79	70	64	59
45-49	128	103	90	83	76
50-54	192	155	134	123	113
55-59	266	215	186	171	157
Female	*$250*	*$500*	*$1000*	*$2500*	*$5000*
0-29	76	61	53	49	45
30-34	89	73	62	57	52
35-39	106	85	72	66	61
40-44	128	104	90	83	76
45-49	151	122	106	98	90
50-54	192	155	134	123	113
55-59	238	190	166	153	141
No. of Children	**Dependent Child(ren) Rate†**				
1	53	37	31	29	26
2+	79	56	47	43	40

† Child(ren) Rate—Child(ren) will be charged at the appropriate deductible Dependent Child(ren) rate.

* *If you prepay for 6 months and you cancel during the term you will not receive a refund.*

New Business Trend Factor Based on Requested Effective Month*

Eff. Date	Factor
1/06	1.819
2/06	1.845
3/06	1.870
4/06	1.897
5/06	1.923
6/06	1.950
7/06	1.977
8/06	2.005
9/06	2.033
10/06	2.062
11/06	2.090
12/06	2.120
1/07	2.149
2/07	2.179
3/07	2.210

**This trend factor, based on your requested effective month, will not change during the benefit period.*

Area Rating Factors

Find the first three digits of the applicant's *resident* address zip code.

MISSOURI	Factor
631,640,641	1.40
630,633	1.30
642-645	1.20
636,637,647-652,658	1.00
634,635,638,639,646	0.90
653-657	0.90

Call your MGA or the plan administrator for additional marketing states.

If Not Applying Online, How Do I Apply For Coverage?

1. Completely fill out the application, answer all the questions, sign and date.
2. Calculate your monthly premium on the "Monthly Rate Calculation Worksheet" above.
3. Method Of Payment section is on the application. You can choose from two payment methods by:
   - Making your check or money order payable to "Empire Fire and Marine Insurance Company" **If paying by check or money order, faxed applications are not acceptable.**
   - Credit card payment of either Visa or Master Card (Legible faxed applications are acceptable only when paying by credit card.)
   - **Company/employer checks or company/employer credit cards are not acceptable.**
4. If you are paying for more than one month, simply multiply the Initial Monthly Remittance by the number of months being paid. If you are prepaying for 6 months, and you cancel during the term you will not receive a refund.

Subsequent Payments

Easy monthly premium payment via check, money order or credit card. If coverage is approved and you pay monthly, you will receive coupons with your insurance Certificate indicating the amount due for each additional month of coverage. Your coverage may remain in force for up to 6 months as long as you prepay or as long as you pay each monthly premium when due.

It is your responsibility to mail your monthly premium remittance coupon with the amount due.

When is Coverage Effective?

The earliest effective date coverage can be assigned is 12:01 a.m. on the date following the postmark date on the envelope (or the fax date) or the date requested on the application, if later. If the postmark/fax date is the 28th or later, the coverage effective date will be the first of the following month or date requested, if later. If the original envelope is not included, the effective date will be the date received by the administrator (NIA Corporation).

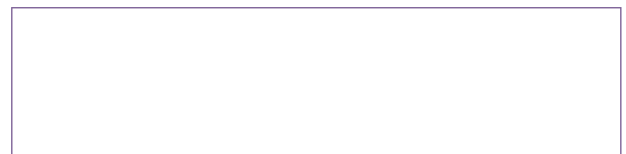
Administered By

PO Box 150832, Denver, CO 80215
Tel 800-323-2586, Fax 303-232-4758

National Program Manager

American Select
INSURANCE MANAGEMENT CORPORATION

Marketed By



The American Select Short Term Major Medical Plan For Individuals And Their Families

Use the Physicians, Hospitals or Other Providers of Your Choice

The Policy Will Pay 100% of Covered Expenses up to the $2,000,000 Benefit Period Maximum After You Have Met Your Out-Of-Pocket Expenses(1)	SHORT TERM MAJOR MEDICAL PLAN
Choose Your Benefit Period Deductible	❑$250 ❑$500 ❑$1000 ❑$2500 ❑$5000
Then Choose Your Coinsurance. Coinsurance Maximum does not include benefit period deductibles, service deductibles or non-covered expenses.	*Coinsurance* / *Coinsurance Maximum* ❑ 80/20%-$5,000 .... $1000 ❑ 50/50%-$5,000 .... $2500
Physician Office Visit	Subject to benefit period deductible and coinsurance
Outpatient Prescription Drug Coverage(2)	Subject to benefit period deductible and coinsurance
Hospital Emergency Room Service Deductible(3) (per occurrence)	$50 (waived if admitted as an inpatient following emergency room visit)
Outpatient MRI, Cat Scan and Nuclear Imaging Service Deductible(3) (per test)	$100

(1) Out-of-pocket expenses include any applicable deductibles, coinsurance, amounts in excess of usual, reasonable and customary charges and non-covered expenses.
(2) Outpatient prescription drugs are subject to a $10,000 per person benefit period maximum.
(3) Service deductible is in addition to the chosen benefit period deductible/coinsurance and does not apply to the benefit period deductible.

PLAN BENEFITS AND FEATURES

Plan Benefits are subject to applicable benefit period deductible, coinsurance and/or service deductible(s).

- Alcohol and Drug Abuse Treatments - Inpatient maximum 30 days; Outpatient maximum 20 total visits
- Ambulance Service ($1000 for ground or water, $5000 for air max. per occurrence)
- Ambulatory Surgical Centers
- Anesthetics and their Administration
- Chemotherapy and Radiation Therapy
- Dental Treatment as a result of a covered injury to sound natural teeth
- Dressings, Sutures, Casts, Splints, Trusses, Crutches
- Emergency Treatment received outside the U.S.
- Home Health Care – up to 40 visits per benefit period
- Hospital Daily Room and Board (semi-private room rate)
- Hospital Inpatient Miscellaneous Medical Services and Supplies
- Hospital Outpatient Services
- Intensive Care
- Mammograms–Females: One baseline ages 35-39 and one every year for ages 40 and older
- Organ Transplants or Replacements
- Oxygen and other Gases
- Pap Smear–One screening per benefit period including the physician's office visit
- Physical, Respiratory and Speech Therapy for Rehabilitative Treatment
- Physician Charges
- Rental of durable medical equipment
- Skilled Nursing Facility for convalescent care
- Spinal Manipulation and Other Manipulative Therapy-15 visits per benefit period maximum
- X-rays, Laboratory Tests, and Other Diagnostic Tests

Plan benefits may be subject to exclusions, limitations and maximum benefits and may vary by state. Complete description of benefits is contained in the Master Policy and outlined in the certificate.

10 Day Free Look Provision

Renewability

Coverage under this policy is non-renewable. Issuance of a second or subsequent certificate to a covered person under this policy does not continue coverage. Each benefit period is separate and distinct from any prior benefit period. You must submit a new application and be approved for coverage. Any illness or injury which may have occurred under a prior benefit period will be subject to the pre-existing condition provision during this benefit period.

Exclusions & Limitations

Except as specifically provided for in the policy or mandated by law, the policy does not cover:

preexisting conditions • expenses incurred before the effective date • expenses incurred after coverage under the policy terminates, regardless of when the condition originated • expenses incurred to treat complications resulting from treatment, drugs, supplies, devices, procedures or conditions which are not covered under the policy • experimental, investigational, or unproven services • expenses reasonably determined to be educational • amounts in excess of the usual, reasonable and customary charges • expenses the covered person is not required to pay, which are covered by other insurance, except Medicaid, or which would not have been billed if no insurance existed • care in government institutions unless the covered person is obligated to pay for such care • charges incurred for illness or injury that arises out of, as a result of, or in the course of employment • non-emergency treatment received outside of the United States • charges incurred by a covered person while on active duty in the Armed Services • expenses resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection • expenses incurred or expense related thereto, while engaging in an illegal act or occupation or during the commission, or the attempted commission, of a felony • expenses incurred while participating in professional, semi-professional or intercollegiate sports, or while participating in a rodeo, either professional or for recreation • pregnancy or childbirth, except for complications of pregnancy • charges incurred for voluntary termination of pregnancy • any drug (including birth control pills), implants or injections, supply, treatment, device or procedure that prevents or terminates conception and/or childbirth • diagnosis and treatment of infertility • any drugs, supplies, treatments, devices or procedures related to sex transformation or reversal thereof, sexual dysfunctions, penile implants or sexual inadequacies • sterilization or reversal of sterilization • physical exams or other services or supplies not needed for medical treatment • prophylactic treatment, including surgery or diagnostic testing • psychiatric care or treatment of a nervous or mental disorder • programs, treatment, supplies, or procedures for tobacco use cessation • expenses resulting from intentional self-inflicted injury, suicide or attempted suicide, if sane • charges incurred which result from: (a) the voluntary taking of drugs, except those taken as prescribed by a physician, (b) the voluntary taking of poison, (c) the voluntary inhaling of gas, or (d) being under the influence of alcohol • dental treatment or care • orthodontia or other treatment involving the teeth and supporting structures • treatment by any method for jaw joint problems including temporomandibular joint dysfunction (TMJ) • surgical or non-surgical correction of refractive error; vision therapy; routine vision exams; eyeglasses or contact lenses for the treatment of aphakia • routine hearing exams to assess the need for or change to hearing aids; the purchase, fittings or adjustments of hearing aids • cosmetic or reconstructive procedures, services or supplies • charges for breast reduction unless medically necessary • charges for breast augmentation • removal of breast implants • medications and drugs, including vitamins and vitamin–mineral supplements, available over-the-counter (OTC) whether or not by a physician's prescription order • any expense related to the treatment of hair loss • treatment of weak, strained, flat, unstable, or unbalanced feet, metatarsalgia, bunions or the removal of corns, calluses or toenails • charges for blood or blood plasma that has been replaced • treatment of autism, developmental delays and learning disabilities, testing and training for education or vocation • treatment of acne • treatment of obesity, including surgery for reconstruction, repair or reversal of a gastric bypass • transportation charges • services or supplies for personal comfort or convenience, including custodial care or homemaker services • services and/or supplies furnished and/or provided by an immediate family member • any charges incurred in connection with a hospital admission on Friday or Saturday unless the attending physician states in writing that the admission was an emergency • immunizations not necessary for the treatment of an illness or injury • expenses incurred for occupational therapy • acupuncture unless the charges incurred are in lieu of anesthesia • marriage or family counseling • sex therapy • private duty nursing while not confined in a hospital • hypodermic needles, syringes, support garments, other non-medical items, regardless of their intended use • growth hormones, drugs prescribed for weight control or obesity, smoking deterrents, Rogaine, Retin A, drugs prescribed for cosmetic purposes, vitamins and minerals regardless of the purpose for which prescribed

Pre-Existing Conditions–Limitation

An illness or injury of a covered person for which the covered person has received medical advice, treatment, services, diagnostic tests, consultation or medication during the twelve months prior to the covered person's effective date of coverage under the policy.

Termination of Insurance

Insurance will remain in force until the earliest of:

- The date there is fraud or material misrepresentation with regard to the policy or its benefits.
- The date the member's premium is due if not received by the end of the grace period.
- The premium due date following the date the policy terminates.
- The date of death of the covered member.
- The premium due date following the date the insurer terminates all certificates in a specific state.
- Dependent child's coverage ends on the premium due date following the date the covered child's eligibility ends. (Termination of covered member's insurance will also result in dependent termination.)

Unless terminated due to any of the above, coverage will remain in force for up to 6 months as long as you prepay or as long as you pay each monthly premium when due. **If not prepaying, it is your responsibility to mail your monthly premium remittance coupon with the amount due.**

Failure to fully disclose information can result in rescission (voiding) of coverage and the denial of a claim. Please refer to the Application and the Certificate of Insurance for further details.

This brochure is a brief description of the important features of the Master Group Policy. It does not include all state mandated benefits or requirements. It is not a contract. Complete description of benefits is contained in the Master Policy and outlined in the Certificate.

The Master Group Policy is issued to Consumer Benefits of America in the state of Illinois. Benefits, exclusions, limitations and availability may vary by state.

Premium varies based upon the benefits selected.

Check for state availability.
Policy Form #EM 29 01 (08-01)-P   Master Group Policy #STM 10/01-001

Mail application to:
NIA Corporation
PO Box 150832, Denver, CO 80215

Consumer Benefits of America
Short Term Health Insurance Application

Insured by:
Empire Fire and Marine Insurance Company

Applicant Name (print first, middle, last)

Street Address Apt. No.

City State Zip

Work Phone ( ) Home Phone ( )

Persons Proposed for Coverage	Relationship	Date of Birth Mo.	Day	Yr.	Sex	Social Security Number
	Applicant					- -
						- -
						- -
						- -
						- -
						- -

Requested Effective Date:
❏ Day following postmark/fax date *or* later ___/___/___

Coverage Term Up To 6 mo. | Coinsurance: ❏80/20 ❏50/50 | Deductible: ❏$250 ❏$500 ❏$1000 ❏$2500 ❏$5000 | Total Initial Remittance $__________

1. Are all proposed insureds US citizens? ❏Yes ❏No If no, has any proposed insured who is not a US citizen resided in the US for a period less than the past six months? ❏Yes ❏No If yes, state name of such person(s) and such person(s) is/are not eligible for this coverage. ________
2. Will you or any person proposed to be insured have any other individual or group major medical coverage in force on the effective date of the coverage for which you are now applying? ❏Yes ❏No If yes, state the name of such person(s) and such person(s) is/are not eligible for this coverage. ________
3. Is any family member, whether applying for coverage or not, now pregnant, an expectant parent, or in the process of adopting a child? ❏Yes ❏No If yes, a certificate cannot be issued, even if the pregnant individual, expectant or adoptive parent is/are not applying for coverage.
4. Have you or any proposed insured received any medical or surgical consultation, medical advice, care, diagnosis or treatment, including medication, within the last five years for: stroke, trans-ischemic attack; aneurysm; carotid artery disease; heart attack, heart surgery (including catheterization), heart disease, coronary artery disease; primary pulmonary hypertension; leukemia, internal cancer, carcinoma in-situ, tumor, melanoma or melanoma in-situ? ❏Yes ❏No If yes, state name of such person(s) and such person(s) is/are not eligible for this coverage. ________
5. Have you or any proposed insured received any medical or surgical consultation, medical advice, care, diagnosis or treatment, including medication, within the last five years for: diabetes; Hepatitis C; cirrhosis of the liver; kidney disease; ulcerative colitis; multiple sclerosis; Alzheimer's Disease; Parkinson's Disease; chronic obstructive pulmonary disease or emphysema, hemophilia or any disease or disorder of the blood, except iron deficiency anemia? ❏Yes ❏No If yes, state name of such person(s) and such person(s) is/are not eligible for this coverage. ________
6. In the last five years, have you or any proposed insured been diagnosed or treated, or been advised to seek treatment by a health practitioner for alcohol, drug or substance abuse or excessive use; psychological, psychoneurotic or psychotic disease or disorder, other than anxiety or depression? ❏Yes ❏No If yes, state name of such person(s) and such person(s) is/are not eligible for this coverage. ________
7. Have you or any proposed insured ever been diagnosed with or medically treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex, or been tested positive for HIV or HTLV III? ❏Yes ❏No If yes, state name of such person(s) and such person(s) is/are not eligible for this coverage. ________

I understand that, if persons proposed for coverage are eligible and coverage is issued: (1) Upon receipt of the application and correct premium at the administrator's office, the coverage effective date assigned will be 12:01 a.m. on the date following the fax date or the postmark date on envelope or the date I request, if later. If the postmark/fax date is the 28th or later, the coverage effective date will be the first of the following month or date I request, if later; (2) **Pre-existing conditions will not be covered;** (3) **Coverage is not renewable;** (4) Deductible changes or dependent additions or deletions (except newborns or adopted children) cannot be made after coverage is in effect.

By my signature below, I certify that I understand, declare and agree as follows: that the responses contained herein will be relied upon by Empire Fire and Marine Insurance Company (Empire) in the issuance of a certificate of insurance; that all statements contained herein are true and correct to the best of my knowledge and that no material information has been withheld or omitted; that Empire is not bound by any statement made by or to any agent unless written herein; that the agent has no authority to advise me to omit or inaccurately report any information requested herein; that material omissions or misstatements may be grounds for rescission under the policy.

X________ Signature of Applicant (or parent if applicant is under age 18) ________ Date ________ City, State

X________ Signature of Spouse (if applying) ________ Date ________ City, State

________ Date ________ Agent Name (please print) X________ Agent Signature ________ Agent Number

Form EM 29 08 (10-03)-APP-MO

Application valid for 30 days only from applicant's signature date.

Method of Payment: ❏Check (Make check payable to Empire Fire and Marine Insurance Company.) ❏VISA ❏Master Card I authorize Empire Fire and Marine Insurance Company, its administrator or NIA Corporation to bill my VISA or Master Card for the Total Initial Remittance from the reverse side. I also understand there will be no refund of the initial premium after the 10 day free look period. Payment by credit card is subject to acceptance of the credit card issuer and clearance of the debit.

Cardholder Name________ Cardholder Signature X________

Account No.________ Exp. Date ____/____/____

CONSUMER BENEFITS OF AMERICA ASSOCIATION CHOICE MEMBERSHIP ENROLLMENT FORM

Please enroll me as a choice member of the Consumer Benefits of America Association. My membership entitles me to money saving Association benefits. I understand that my monthly membership dues will be collected by mode selected. **Application for our Short Term coverage is only available to CBA members.**

*Name________ Home Phone (________)________

Address________ City________ State_____ Zip ______

*Applicant's Signature X________ Date ________

**Parent or guardian if applicant is under age 18.*

MISSOURI

Consumer Benefits of America, Association Member Benefits Office, Denver, CO

EMPIRE FIRE AND MARINE INSURANCE COMPANY
AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS
for Enrollment/Eligibility for Benefits Determinations

I authorize any and all physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, health plans, pharmacy benefit managers, pharmacies or pharmacy-related facilities; health care providers, MIB Group, Inc., MIB, Inc. (MIB), e-nable Corporation, IntelRx, LLC, insurance companies and their business associates and those persons or entities providing services to the insurers' business associates which are related in any way to their insurance plans to disclose my health information and the health information of my minor dependents. This specifically includes the release of all medical records including without limitation those containing information relating to diagnoses, treatments, consultation, care, advice, laboratory or diagnostic tests, physical examinations, recommendations for future care, prescription drug information, alcohol or drug abuse, mental illness or information regarding communicable or infectious conditions, such as HIV and/or AIDS. However, this authorization does not include use or disclosure of "psychotherapy notes". Medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date are not considered "psychotherapy notes".

Empire Fire and Marine Insurance Company and its business associates (specifically including, but not limited to, Insurers Administrative Corporation and/or NIA Corporation) and those persons or entities providing services to Empire's business associates which are related in any way to Empire's health plans are authorized to receive and use my health information to make enrollment/eligibility for benefit determinations, specifically including, but not limited to, underwriting and risk rating determinations. If coverage is issued, such determinations may include determinations as to whether coverage should be rescinded or reformed if I have made any omission(s) or misrepresentation(s) in my application which are material to the underwriting process.

I understand that if I refuse to sign this authorization, my application for insurance with Empire Fire and Marine Insurance Company will be rejected. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I also understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or the insurance company exercises a legal right to contest a claim or the policy itself, by sending a written revocation to Empire Fire and Marine Insurance Company, c/o Privacy Officer, ASIM, PO Box 150489, Denver, CO 80215.

This authorization will expire 24 months after the date signed. This authorization revokes any previous restrictions concerning access to such information. **A copy of this authorization is as valid as the original.**

Signature of each Individual over Age 18 (and Parent or guardian on behalf of any minor dependent to be covered):

	Signature	Soc. Sec. No.	Date
Applicant			
Spouse (if applying)			
Dependent over 18 (if applying)			
Dependent over 18 (if applying)			

You must complete the following if applying for coverage for a minor dependent:
Please check the appropriate box if you are signing for one or more minor dependents:
❏ Parent ❏ Legal Guardian ❏ Trustee (If trustee or legal guardian, please supply legal documentation)