

AMERICAN HEALTH SHIELD SHORT TERM MEDICAL

30-Day Premium Rates / Effective 05/01/2002

Age Band	\$250 Deductible	\$500 Deductible	\$1,000 Deductible	\$2,000 Deductible
	MALE/FEMALE	MALE/FEMALE	MALE/FEMALE	MALE/FEMALE
0-29	\$ 86	\$ 76	\$ 63	\$ 40
30-34	106	94	75	46
35-39	122	108	87	53
40-44	142	126	101	61
45-49	169	149	120	73
50-54	195	173	138	84
55-59	255	226	180	110
60-64	354	313	251	152
Per Child	\$53	\$47	\$42	\$28

Rate Calculation in 3 Easy Steps

Applicant: \$ _____

Spouse: \$ _____

Child(ren): \$ _____

Sub-Total: \$ _____

Area Factor: X _____

Sub-total: \$ _____

Admin. Fee: \$ 12.00

30-Day Sub-Total: \$ _____

Enrol. Fee: \$ 10.00

TOTAL DUE \$ _____

1. Select the Deductible and then, based upon gender and age, locate and total premium rates for all persons to be insured.
2. Multiply the sub-total by the proposed insured's residence state zip code area factor and add the monthly administration fee.
3. Remit payment for the Total Due to Co-ordinated Benefit Plans, Inc. by: check, money order, or credit card. Mail the completed and signed application with your initial payment to:

Co-ordinated Benefit Plans, Inc.
P.O. Box 20594
Tampa, FL 33522-0594

NOTE: Plan costs for 60 to 180 day Benefit Periods can be paid in monthly installments or in one lump-sum. For lump-sum payments, multiply the 30-Day Sub-Total by (2=60 days; 3=90 days; 4=120 days; 5=150 days; 6=180 days) and add the enrollment fee. Questions? Call toll-free 1-800-753-1000.

Make check payable to Co-ordinated Benefit Plans, Inc. or, if paying by credit card, complete credit card section below and fax both sides of the completed application to 1-727-799-9093 for immediate processing.

PAYMENT BY CREDIT CARD AUTHORIZATION

I authorize Co-ordinated Benefit Plans, Inc. to charge my credit card on the payment due date(s) for insurance premium(s) and fees which become due for the Benefit Period issued to the insured applicant.

Please charge my: MasterCard VISA
(debit cards are not accepted)

ACCOUNT NUMBER _____ / _____
EXP DATE

PRINT CARDHOLDER'S FULL NAME (Exactly as shown on card)

RELATIONSHIP TO INSURANCE APPLICANT _____

SIGNATURE OF CARDHOLDER _____ DATE _____

PRINTED 9/03 MT

State /
Zip Code Prefix

Area
Factor

MONTANA

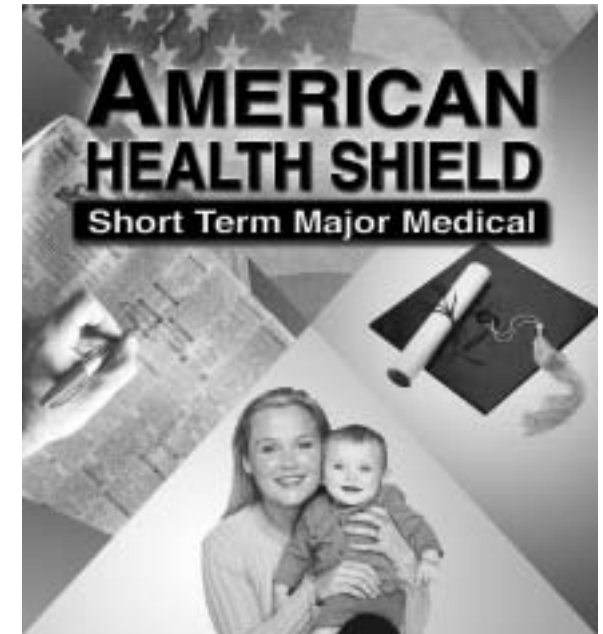
590-593, 595, 5960.88
598, 5990.82
All Other0.74

STATE AVAILABILITY

This application must be completed by applicants that reside in the state(s) shown above.

If you do not reside in the state(s) shown above, contact your independent insurance agent or call toll-free 1-800-753-1000 for product availability, state specific applications and rates.

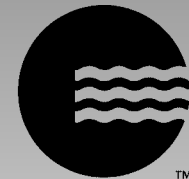
American Health Shield - Short Term Medical is available in the following states: AK, AL, AR, AZ, CA, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KY, LA, MD, MI, MN, MO, MS, MT, NC, ND, NE, NM, NV, OH, OK, PA, RI, SC, TN, TX, UT, VA, WI, WV, and WY.



MONTANA

APPLICATION, RATES & AREA RATING FACTORS

Underwritten By:



CHESAPEAKE
LIFE INSURANCE
A UICI Company

Forward Application & Payment To:

Co-ordinated Benefit Plans, Inc.

P.O. Box 20594
Tampa, Florida 33622-0594

PROPOSED INSURED					COVERAGE INFORMATION						
FULL LEGAL NAME FIRST, MIDDLE, LAST			SOC. SEC. #	DATE OF BIRTH	GENDER		PREMIUM PAYMENT METHOD (choose one)				
RESIDENCE / HOME STREET ADDRESS					<input type="checkbox"/> Pre-Paid <input type="checkbox"/> Monthly						
CITY		STATE MT	ZIP CODE	TELEPHONE NUMBER ()		REQUESTED EFFECTIVE DATE (choose one)					
FAMILY MEMBERS TO BE INSURED					<input type="checkbox"/> Day after U.S. Postmark						
Spouse	FULL LEGAL NAME (FIRST, MIDDLE, LAST)		SOC. SEC. #	DATE OF BIRTH	GENDER		<input type="checkbox"/> Postponed Date: ___/___/___				
Child	FULL LEGAL NAME (FIRST, MIDDLE, LAST)		SOC. SEC. #	DATE OF BIRTH	GENDER		BENEFIT PERIOD REQUESTED (choose one)				
Child	FULL LEGAL NAME (FIRST, MIDDLE, LAST)		SOC. SEC. #	DATE OF BIRTH	GENDER		<input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days				
Child	FULL LEGAL NAME (FIRST, MIDDLE, LAST)		SOC. SEC. #	DATE OF BIRTH	GENDER		<input type="checkbox"/> 120 Days <input type="checkbox"/> 150 Days <input type="checkbox"/> 180 Days				
Child	FULL LEGAL NAME (FIRST, MIDDLE, LAST)		SOC. SEC. #	DATE OF BIRTH	GENDER		REQUESTED DEDUCTIBLE (choose one)				
Child	FULL LEGAL NAME (FIRST, MIDDLE, LAST)		SOC. SEC. #	DATE OF BIRTH	GENDER		<input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000				

- Do you or any applicant to be insured have any hospital, major medical, group health, or medical insurance coverage in force that will not terminate prior to the effective date of this coverage? YES NO
 a) Will this plan replace existing coverage? (If YES, the applicable replacement form must be signed.) YES NO
 b) When will existing coverage expire? ___/___/___
- Are you, your spouse, or any dependent, (whether listed on the application or not) now pregnant or are you an expectant father of any unborn child?.. YES NO
- Have you or any person to be insured been declined for insurance due to health reasons? YES NO
- Have you or any applicant to be insured in the past five years received any treatment, medication, or medical or surgical advice for heart or circulatory system disorder, including heart attack or chest pain, stroke, diabetes, cancer or tumor, leukemia or any blood disorder, alcohol or drug abuse or dependency, immune system disorder or been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? YES NO

NOTE - The plan cannot be issued if YES is answered on any of the above questions, 2, 3, or 4. *Coverage cannot become effective prior to termination of any other insurance coverage in force. Under no circumstances can coverage become effective prior to the date this application is completed, signed and correct initial payment is received by the Company. **RIGHT TO EXAMINE CERTIFICATE FOR 10 DAYS:** If the Named Insured is not satisfied, return the certificate to the Company within 10 days after it is delivered. All premiums will then be refunded. If the certificate is returned, it shall be void from the beginning. The parties shall be in the same position as if no certificate had been issued. **NO RECOVERY FOR PRE-EXISTING CONDITIONS** – No benefits will be provided during the term of the Group Policy for any Pre-existing Condition as defined in the Group Policy.

AGREEMENT – I have read this application and represent that each of the above statements and answers are complete and true to the best of my knowledge and belief, and I understand that the answers to the above questions shall be the basis of any coverage issued, and that any untrue answer may operate to void this coverage. Any material misstatement or omission of information made on this form will be considered a misrepresentation and may be the basis of claim denial or later rescission of coverage issued on the basis of the above information. Such rescission and termination of coverage will apply to the Named Insured and his or her Dependents without liability to the Company. Coverage is not effective until approved and issued by The Chesapeake Life Insurance Company. I understand that the Company will not pay benefits during the term of coverage for loss due to any medical condition or illness I or any person to be insured may now have or had.

I hereby authorize any insurance company, organization, employer, hospital, physician, pharmacist, educational institution, or other person or entity to release to the Company such information as it may require to process claims.

APPLICANT'S SIGNATURE		DATE		E-MAIL ADDRESS	
FOR AGENT USE ONLY	AGENT'S FULL NAME (FIRST, MIDDLE, LAST)			SOC. SEC.#	TELEPHONE NUMBER
	MAILING ADDRESS		CITY	STATE	ZIP CODE
			FACSIMILE NUMBER		

STP-EA (1)

FORWARD COMPLETED APPLICATION AND PAYMENT TO: C.B.P.I. • P.O. BOX 20594 • TAMPA, FL 33622-0594

MONTANA