



Health insurance plans  
endorsed by ABBA.

# IPA Producer Guide

Business procedures and  
underwriting guidelines

## Hospital Indemnity Plans

Specified Hospital, Surgical and  
Critical Illness Insurance Indemnity  
Benefits for You and Your Family

### CHOICE Solutions

With Available Preventive Wellness  
and Diagnostic Testing Benefits

CHOICE Solutions is a Fixed Indemnity Hospital and Surgical insurance plan endorsed by America's Business Benefit Association (ABBA), and in the state of Oregon, Communicating for America (CA). Plans are available to members of ABBA, CA, and also to residents of certain states on an individual basis; please ask your representative for details. Underwritten by Independence American Insurance Company, rated A- (Excellent) by A.M. Best. Marketed by IPA Family.

Independence American  
Insurance Company  
Independence Holding Group

MAC HPP 1012



This guide was designed for the fixed indemnity hospital and surgical insurance. It contains important information about new business processing and underwriting guidelines to assist the sales representative in determining the eligibility of prospects and applicants. By following these procedures and guidelines, you will help facilitate the prompt review, processing and issuance of your applications. Throughout this guide, producers will be referred to as “you,” IHC Health Solutions will be referred to as “us” and Independence American Insurance Company will be referred to as “the company.”

Nothing in this guide is intended to guarantee that the described underwriting practices apply in all circumstances. The company’s actual underwriting practices in effect at the time an application is reviewed will apply to the processing and underwriting of new business. Also, some states have special benefits and requirements not addressed in this guide.

For additional information, please refer to the following documents:

- Plan brochure
- Enrollment application
- Your producer’s agreement

## Important Addresses and Phone Numbers

### IHC Health Solutions

#### **Underwriting**

1173 W. Main St. Ste. E  
Whitewater, WI 53190

**Phone:** 866-472-6555

**Fax:** 602-674-9015

#### **UW e-mail:**

[underwriting@ihcgroup.com](mailto:underwriting@ihcgroup.com)

#### **Policy Services**

PO Box 37457  
Phoenix, AZ 85069-7457

**Phone:** 866-500-6862

**Fax:** 602-906-4745

#### **Administration e-mail:**

[policyservices@ihcgroup.com](mailto:policyservices@ihcgroup.com)

#### **Claims**

*(PPO claims use the address on ID card)*

P.O. Box 21456  
Eagan, MN 55121-0456

**Phone:** 888-794-8976

**Fax:** 815-316-6730

#### **Claims e-mail:**

[claims@ihcgroup.com](mailto:claims@ihcgroup.com)

## Independence American Insurance Company (IAIC)

IAIC is a member of The IHC Group, composed of Independence Holding Company (NYSE: IHC) and its operating subsidiaries. In business since 1973, IAIC is domiciled in Delaware and headquartered in New York. IAIC is licensed to conduct business in 49 states and the District of Columbia. IAIC products include Hospital Indemnity, short-term medical, employer medical stop-loss, provider excess loss, small group major medical, and major medical for individuals and families. Product availability varies by state.

## America’s Business Benefit Association (ABBA)

Independent Solutions are group association plans available to members of America’s Business Benefit Association (ABBA). ABBA is a national nonprofit association that provides individuals, small businesses and the self-employed consumer benefits, services and health-related purchases, including access to valuable association-endorsed health care insurance benefits. Plans are available to members of ABBA and also to residents of certain states on an individual basis; please contact your manager for details.

There is no ownership affiliation between ABBA and IAIC.

# Eligibility of Applicants

## Issue Ages for Individual or Family Coverage

Adult applicants must be 19-64.5 years of age. A spouse currently residing in the same household as the primary applicant and under age 64.5 is considered an eligible dependent. We do not recognize common-law relationships or domestic partners unless required by state law. Dependent children must be under age 26 (may vary by state law). Coverage is not available for children without an adult on the same plan.

## Adopted Children

Coverage for adopted children begins on the date of placement with the insured. Placement means that the insured has physical custody of the adopted child and is the court-appointed guardian or has final adoption papers. The primary insured must notify us in writing within 31 days of placement to continue coverage. If notice and payment (if applicable) are not received within 31 days of placement, the adopted child is subject to full underwriting.

## Legal Custody

Dependents who do not meet the basic definition of an eligible dependent but who are in the legal custody of the insured may be considered for coverage subject to review of legal custody documents. Generally, temporary custody or powers of attorney are not considered sufficient legal documentation. There must be permanent custody documented by court order to qualify as an eligible dependent, except as otherwise mandated by state law.

## Resident State

The Independent Solutions plan being applied for must be available for sale in the applicant's primary state of residence. The application must be signed in the applicant's residential state, or you must be licensed in both the residential state and the state in which the application was signed. Premiums are based on the rates applicable to the applicant's primary state of residence and are adjusted to reflect changes in residence when they occur. Benefits are generally based on the owner's primary state of residence.

## Foreign Nationals

American citizenship is not mandatory under this plan as long as the applicant is a legal resident of the United States. A legal resident is defined as someone who is living in the United States on a full-time basis and who has been issued a green card or permanent visa status, with only an occasional stay outside of the United States.

We require a Social Security number only for adults who are applying for coverage. If an adult does not have a Social Security number, we can accept a copy of his/her "green card" or permanent visa to validate residency.

## Acceptable Visa Categories

|      |       |      |     |     |     |
|------|-------|------|-----|-----|-----|
| DV-1 | H-1B1 | IR-2 | K-1 | L-1 | V-1 |
| DV-2 | H-1C  | IR-3 | K-2 | L-2 | V-2 |
| EB-5 | H-4   | IR-4 | K-3 | TN  | V-3 |
| H-1B | IR-1  | IR-5 | K-4 | TD  |     |

## Overseas Travelers

Persons to be covered must not be planning or considering extended foreign travel, nor can they live outside the United States for more than three months of the year. Dependents who are studying abroad are ineligible for coverage since they would be taking residence in a foreign country.

## Medicare Eligible Individuals

Applicants who are already eligible to be covered under Medicare are not eligible for coverage under the Choice Solutions plan. The plan automatically terminates when the insured attains age 65.

# Underwriting

## Completion of the Application

Each question on the application must be specifically asked of the applicant and the answer recorded as given. It is never allowable for you to ask a general question such as, “Are you in good health?”, and upon receiving a “yes” reply, answer all health questions with a “no” answer. All answers must come directly from the applicant. All paper applications must be completed in blue or black ink. It is not sufficient to answer questions with dashed or ditto marks. If an error is made, the primary applicant should cross through the word or line with a single stroke, then initial and date the correction. White-out or correction tape should never be used on an application. Under no circumstances should a health application be backdated.

## Underwriting Decisions

This manual contains the decision matrix used to underwrite individual(s) for the Hospital Indemnity Plan. Since this is an “accept/reject” approach and the underwriting process is designed to happen online, this Producer manual serves as the underwriting manual for the Hospital Indemnity Plan.

The underwriting action is based on the condition(s) disclosed by each applicant. Based on affirmative answers to the medical questions contained on the application, coverage for the applicant(s) at the end of the electronic enrollment process will be issued as applied for or declined.

## Height/Weight for each applicant for ages 15+ only (under age 15, no action applies)

### Adult Male Build Chart Ages 15 and Over

| Height | Max Std | 50% Load | Decline |
|--------|---------|----------|---------|
| 4'10"  | 183     | 184-217  | 218+    |
| 4'11"  | 187     | 188-223  | 224+    |
| 5'0"   | 190     | 191-226  | 227+    |
| 5'1"   | 192     | 193-229  | 230+    |
| 5'2"   | 196     | 197-234  | 235+    |
| 5'3"   | 200     | 201-238  | 239+    |
| 5'4"   | 206     | 207-246  | 247+    |
| 5'5"   | 212     | 213-252  | 253+    |
| 5'6"   | 218     | 219-260  | 261+    |
| 5'7"   | 224     | 225-266  | 267+    |
| 5'8"   | 231     | 232-275  | 276+    |
| 5'9"   | 239     | 240-285  | 286+    |
| 5'10"  | 242     | 243-290  | 291+    |
| 5'11"  | 248     | 249-296  | 297+    |
| 6'0"   | 253     | 254-302  | 303+    |
| 6'1"   | 258     | 259-311  | 312+    |
| 6'2"   | 266     | 267-316  | 317+    |
| 6'3"   | 274     | 275-326  | 327+    |
| 6'4"   | 288     | 289-347  | 348+    |
| 6'5"   | 294     | 295-354  | 355+    |
| 6'6"   | 301     | 302-363  | 364+    |
| 6'7"   | 310     | 311-371  | 372+    |
| 6'8"   | 317     | 318-379  | 380+    |
| 6'9"   | 324     | 325-391  | 392+    |
| 6'10"  | 330     | 331-399  | 400+    |
| 6'11"  | 338     | 339-409  | 410+    |

### Adult Female Build Chart Ages 15 and Over

| Height | Max Std | Max 50% | Decline |
|--------|---------|---------|---------|
| 4'10"  | 163     | 164-189 | 190+    |
| 4'11"  | 168     | 169-194 | 195+    |
| 5'0"   | 173     | 174-198 | 199+    |
| 5'1"   | 178     | 179-204 | 205+    |
| 5'2"   | 183     | 184-209 | 210+    |
| 5'3"   | 188     | 189-214 | 215+    |
| 5'4"   | 193     | 194-220 | 221+    |
| 5'5"   | 198     | 199-226 | 227+    |
| 5'6"   | 203     | 204-231 | 232+    |
| 5'7"   | 208     | 209-236 | 237+    |
| 5'8"   | 213     | 214-241 | 242+    |
| 5'9"   | 220     | 221-249 | 250+    |
| 5'10"  | 227     | 228-256 | 257+    |
| 5'11"  | 234     | 235-265 | 266+    |
| 6'0"   | 241     | 242-274 | 275+    |
| 6'1"   | 248     | 249-282 | 283+    |
| 6'2"   | 256     | 257-288 | 289+    |
| 6'3"   | 261     | 262-293 | 294+    |
| 6'4"   | 266     | 267-301 | 302+    |
| 6'5"   | 273     | 274-306 | 307+    |
| 6'6"   | 278     | 279-311 | 312+    |

|  |   |
|--|---|
| <p><b>Is any person whether or not applying for coverage, pregnant, in the process of adopting or undergoing infertility treatment or use of a surrogate mother?</b></p>   | <p>All members of the family are declined for coverage</p>                                    |
| <p><b>In the past 5 years has any person applying for this coverage been diagnosed with, received medical advice or treatment for (including been prescribed medications), or had symptoms of any of the following conditions:</b></p>   | <p>Underwriting action applies to the applicant to whom the affirmative response applies.</p> |
| <p>Heart disease, stroke, transient ischemic attack, coronary artery disease, peripheral vascular disease, carotid artery disease, coronary bypass, angioplasty or stent, atherosclerosis, or congenital heart disease?</p>  | <p>Yes = Decline</p>  |
| <p>Cancer (other than basal or squamous cell skin cancer), or malignant melanoma?</p>  | <p>Yes = Decline</p>  |
| <p>Disease or disorder of the brain or central nervous system including but not limited to brain tumor or cyst, muscular dystrophy, multiple sclerosis, cerebral palsy, mental retardation, chorea (Huntington's, Sydenham's or Wilson's Disease or other) or amyotrophic lateral sclerosis?</p> | <p>Yes = Decline</p>  |
| <p>Emphysema, chronic obstructive lung disease (COPD), cystic fibrosis or other chronic lung or respiratory condition (except for asthma or allergies)</p>   | <p>Yes = Decline</p>  |
| <p>Hepatitis B or C, cirrhosis, enlarged liver, liver tumor or hemangioma</p>  | <p>Yes = Decline</p>  |
| <p>Insulin dependent diabetes mellitus pancreatitis</p>  | <p>Yes = Decline</p>  |
| <p>Alcoholism, alcohol abuse, illegal drug use or prescription drug dependence or addiction</p>  | <p>Yes = Decline</p>  |
| <p>Bipolar disorder, schizophrenia, anorexia, bulimia, suicide attempt or other mental or nervous disorder (excluding situational depression, anxiety or attention deficit hyperactivity disorder, ADHD)</p>   | <p>Yes = Decline</p>  |
| <p>Kidney or bladder disorder (excluding resolved stones or urinary tract infections)</p>  | <p>Yes = Decline</p>  |
| <p>Rheumatoid or psoriatic arthritis, quadriplegia, paraplegia, or are you required to use a wheelchair or other device to assist you in ambulation?</p>   | <p>Yes = Decline</p>  |
| <p>Stem cell transplant, organ transplant or disease of the blood (other than iron deficiency anemia)?</p>   | <p>Yes = Decline</p>  |
| <p>Autoimmune disorder including but not limited to systemic lupus erythematosus, dermatomyositis, Sjoren syndrome or myasthenia gravis?</p>   | <p>Yes = Decline</p>  |
| <p>Acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or tested positive for the HIV virus?</p>  | <p>Yes = Decline</p>  |

|   |  |
|---|--|
| <b>In the past 2 years has any person applying for this coverage been diagnosed with, received medical advice or treatment for (including been prescribed medications), or had symptoms of any of the following conditions:</b> | Underwriting action applies to the applicant to whom the affirmative response applies. |
| Herniated or bulging disc, degenerative disk disease of the spine   | Yes = Decline  |
| Ulcerative colitis, Crohn's disease, terminal ileitis or diverticulitis   | Yes = Decline  |
| Gallbladder disease that has not been cured and/or gallstones that have not been removed  | Yes = Decline  |
| Endometriosis, human papilloma virus or chronic menstrual disorder  | Yes = Decline  |
| Replacement of the hip(s) or knee(s)  | Yes = Decline  |

## New Business Checklist

The following must be submitted to apply for coverage: *(Additional forms may be needed based on state requirements)*

1. **Application.** Applications should be submitted online. If necessary, they can also be submitted via fax, e-mail or regular mail. If submitting the application through fax or e-mail, the original application does not need to be mailed unless requested by Underwriting.
2. **HIPAA Authorization for Release of Health Related Information.** This form is required with every application.
3. **Payment.** The applicant can submit the initial payment by credit card or bank draft. The first month's premium, including the one-time application fee, will be charged when the application is received.
4. **Copy of the Premium Quote.** A copy of the quote must be sent with the application. Premium rates are based on numerous factors including but not limited to age, tobacco usage and resident state.
5. **Confirmation of Sole Employee Entity.** *(Optional)* A business check will only be accepted in the states of Kansas, Michigan, Oklahoma, Tennessee and Wisconsin if the Confirmation of Sole Employee Entity form is completed. Payment through a business account cannot be accepted in any other state.
6. **Individual Health Plan List Bill Election Form.** *(Optional)* This form must be read and signed by the applicant requesting his/her health insurance premium be included on a list bill. List bill is not available in Colorado, Kansas, Michigan, South Dakota, Tennessee or Wisconsin.
7. **List Bill/Payroll Deduction Setup Form.** *(Optional)* The employer or originator of a list bill must complete this form in order to create a billing to include more than one health insurance certificate/policy.

Scan and email the forms to [underwriting@ihcgroup.com](mailto:underwriting@ihcgroup.com) or fax to 602-674-9015.

# Requirements to Place

## Pending Requirements

Pending requirements are available on the website under the Underwriting Comments tab for the producer. All Hospital Indemnity applications require a telephone verification call. Only the primary applicant may complete this call and it may only be completed after they have reviewed a copy of the application.

Pending requirements can be viewed on the IHC website. Requirements must be received within 30 days of application date to avoid closing the case.

## Producer Kit/Delivery Certificate

All issued certificates and ID cards can be obtained through a web link that will be e-mailed to the insured.

# Pre-Existing Conditions

## Pre-Existing Conditions – 12/12

The certificate/policy defines pre-existing conditions as:

A disease, accidental bodily injury, illness or physical condition for which a covered person:

- Had treatment;
- Incurred charge;
- Took medication; or
- Received a diagnosis or advice from a doctor during the 12 months immediately preceding the covered persons coverage effective date. (The definition of a pre-existing condition may vary by state.)

No benefits will be payable for expenses incurred in connection with pre-existing conditions as defined above until coverage has been in effect for a 12-month period.

# Effective Dates and Billing

## Effective Dates

The applicant may request a plan effective date of the 1st, 8th, 15th or 22nd of the month. The application must be received on or before the requested effective date. The request will be honored if the application can be approved within 15 days of the requested effective date.

## Payment

The applicant's personal check, credit card authorization or bank draft information for the first month's premium, including the application fee, administration fee, managed care fee, and association fee (if applicable) must accompany the application. If an application requests credit card or bank draft mode of payment, a draft of their account is completed upon submission of the application into the underwriting department. Post-dated checks, checking deposit slips, and agency checks are not acceptable. Generally, business checks are accepted in all states except for Florida, Georgia, Kansas, Michigan, North Carolina, Oklahoma, Tennessee, Virginia and Wisconsin. In these states, we accept business checks from business owners who have completed the Confirmation of Sole Entity form and submitted it along with their enrollment package to the company. In Colorado, business checks are accepted only if the applicant is applying for coverage as a "business group of one." Applications received without premiums will be returned unprocessed.

## After the Sale

| Type of change   | Requirements   | Underwriting approval required | Action  |
|--|--|--------------------------------|---|
| <b>Name</b>  | Written request and legal documentation  | No                             | Letter to confirm the change, new certificate face page and ID cards will be sent to the insured  |
| <b>Address</b>   | Phone or written request   | No                             | Letter to confirm the change sent to the insure only if the monthly premium is impacted   |
| <b>Newborn Baby Addition</b>                             | Written request within 31 days   | No – within 31 days            | Letter to confirm addition, new certificate face page and ID cards will be sent to the insured  |
|  | Completed application if after 31 days   | Yes                            |   |
| <b>Add a Family Member</b> ( <i>other than newborn</i> ) | Completed application  | Yes                            | Letter to confirm addition, certificate face page and ID card sent to the insured   |
| <b>Remove a Family Member</b>                            | Written request from the primary insured   | No                             | Letter confirming the change, new certificate face page and ID card sent to the insured   |
| <b>Lower Deductible</b>                                  | Written request from the primary insured with new completed medical section of the application | Yes                            | If approved, letter confirming the change, new certificate face page and ID card (if affected by the change); if declined, letter is sent notifying insured of decision |
| <b>Increase Deductible</b>                               | Written request from the primary insured   | No                             | Letter confirming the change, new certificate face page and ID card (if affected by the change)   |
| <b>Add an Optional Benefit</b>                           | Written request from the primary insured with new completed medical section of the application | Yes                            | If approved, letter confirming the change, new certificate face page; and ID card if declined, letter is sent notifying insured of decision                             |
| <b>Remove an Optional Benefit</b>                        | Written request from the primary insured   | No                             | Letter confirming the change and new certificate face sent to the insured   |



## After the Sale

| Type of change  | Requirements   | Underwriting approval required | Action   |
|---|--|--------------------------------|--|
| <b>Plan change to increase benefits –</b><br><i>(e.g. IAIC 400 to IAIC 600)</i> | Written request from the primary insured with new completed medical section of the application   | Yes                            | If approved, letter confirming the change and new certificate face page; if declined, letter is sent notifying insured of decision |
| <b>Termination of Coverage</b>  | Written request from the primary insured<br><br><i>Note: Depending on the original billing date, terminations are made on the day of the month following receipt of the request or the last fully paid month. Premium refunds will not be paid to insureds on monthly bank draft billing mode.</i> | No                             | Letter to confirm the termination and Certificate of Creditable Coverage sent to insured.  |

### Medical Claim Review

Claims received that are inconsistent with information provided on the application or claims that may be subject to a pre-existing condition limitation are sent to medical review. When a claim is reviewed, the analyst will look at the original application, telephone interview, evaluation of prior coverage and determination of HIPAA eligibility. Investigations will determine if the condition on the claim is a pre-existing condition or if there was a material misrepresentation in the application. The producer and insured will be sent correspondence providing the status of the medical review process.

### Rescission or Reformation of Coverage

False or misleading information on the application may be the basis for rescission or reformation of coverage. Rescission voids the coverage back to the effective date. Reformation allows a rating to be applied to the policy back to the effective date. Be sure that the applicant completes the application accurately, including all answers to medical questions and height and weight information