

Mr./Mrs./Ms. _____. My name is _____ this conversation will be recorded for compliance purposes, and will also serve as a permanent verification record of your membership application. Is it okay for me to record this? **[Member must reply "yes". If member says, "no", read the following: "I'm sorry, Mr. /Ms. _____, our conversation must be recorded in order for us to proceed. May I go ahead and record the remainder of conversation?" If Still No: "Unfortunately we will not be able to process your enrollment today. If "yes", proceed.]**

You were transferred to me to verify the information that you provided to our enrollment representative, _____, regarding your application for the Health Depot Association membership plan.

1. Today is _____ (today's date) and the time is: _____.
2. I am speaking to (Repeat name, address, phone number and email address)? **[Yes/No]**
3. Have you maintained a primary residence in the U.S. for the past 12 months or longer? **[Yes/No]**
4. Your date of birth is _____? **[Yes/No]**
5. You do agree that your effective date is _____? **[Yes/No]**
6. Your initial payment today is \$_____, which represents your first month's membership dues plus a onetime Health Depot Association membership processing fee of \$_____ which is nonrefundable, thereafter, your monthly dues will be \$_____ which will be automatically charged or drafted on the _____ of every month from your debit your credit card/debit card/bank provided to us today, do you agree? **[Yes/No]** **(Please Note: Premier Health Solutions provides the benefits administration and management services for The Health Depot Association. As such, you will see "Premier Health Solutions" on your billing.)**
7. You are the holder of the credit card/debit card or bank account? **[Yes/No]**
If **[No]**: Please place the account holder on the phone to verify the account information.
or
If **[No]**: Please have the account holder call us back with the account information to complete the verification process.
If **[Yes]**: Continue the conversation.
8. If **[Credit/Debit Card]**: The card you provided to me was a **(Visa, MC, Discover, AMEX)** and that card number is _____, expiration is _____ and the CVV code is _____. **[Yes/No]**
or
If **[ACH]**: The routing number you provided is _____ and the account _____. **[Yes/No]**
9. If you are not satisfied with your membership, you may cancel **within 30 days from your effective date** and receive a full refund on your monthly membership dues; **however, your one time enrollment fee is non-refundable.** Do you understand and agree? **[Yes/No]**
10. If you submit a claim under any of the insurance benefits included with your membership, you will be deemed to have accepted the membership and you will not be eligible for any refund. All cancellations must be directed to Member Services at (855) 351-7535. Do you understand and agree? **[Yes/No]**
11. You understand that your Health Depot Association membership also includes many benefits such as Teladoc, ScriptSave Rx, and many other health care, consumer and business benefits? **[Yes/No]**

(DO NOT READ Question #12 to residents of Florida.)

12. You understand that the Discount Medical Plans are provided by Alliance Health Card of Florida, a discount medical plan organization. The features are not health insurance policies and are not available in all areas. The features provide discounts at certain health care providers for medical services and do not make payments directly to the providers of medical services. The member is obligated to pay for all health care services but will receive a discount from those health care providers who have contracted with Alliance Health Card of Florida, Inc. P.O. Box 630858, Irving, TX 75063. **[Yes/No]**

13. You understand that you've selected a membership with Health Depot Association that includes Accident and Sickness Limited Benefit Cash Insurance, and may also include Excess Accident Medical Expense insurance and Accidental Death & Dismemberment insurance benefits? **[Yes/No]**

DO NOT READ question # 14 if member enrolled in Essential Protection Level 1.

14. Please confirm that your beneficiary for the AD&D Insurance policy is **(beneficiary name)**. **[Yes/No]**?

or

Who would you like to name as your beneficiary for the AD&D Insurance policy?

(Add beneficiary name) _____

15. Did your Sales Representative explain that the Accident and Sickness Limited Benefit Cash Insurance does not cover pre-existing conditions for the first 12 months? **[All states except FL, KY, NV]** **[or]** 6 months? **[For FL, KY, NV]** **[Yes/No]**
16. Did your Sales Representative explain that the insurance contains exclusions and offer to read those exclusions to you? **[Yes/No]** **[The answer must be yes. If no, the offer to read the exclusions should be made here, and read if requested.]**
17. You understand that the Accident and Sickness Limited Benefit Cash Insurance, Excess Accident Medical Expense insurance and Accidental Death & Dismemberment insurance is a supplement to health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes. **[Yes/No]**

Read Question 17 to residents of DC or NV only.

18. Do you currently have major medical insurance as required by the Affordable Care Act? **[Yes/No]** **[If NO, read the following: I'm sorry but if you do not have major medical insurance, I cannot enroll you in a membership plan which includes the Accident and Sickness Limited Benefit Cash Insurance. Would you like to hear about another HD membership plan that does not require you to have major medical insurance?]**
19. You understand that if there is any discrepancy between what you thought the Agent told you about the plan and what the actual Insurance Policies state, the policy terms apply? **[Yes/No]**

The Accident and Sickness Limited Benefit Cash Insurance, Excess Accident Medical Expense and Accidental Death & Dismemberment insurance are underwritten by Federal Insurance Company, a Chubb company. Actual coverage is subject to the language of the policies as issued: Accident & Sickness Limited Benefit Cash policy #9908-09-15 and #9907-85-41 and Voluntary Accident policies #9907-85-42 and #9907-85-86 and if applicable, Stand Alone Accidental Death & Dismemberment policy #9907-85-43. Exclusions and limitations apply. Chubb, 202 Halls Mill Road, Whitehouse Station, N.J. 08889.

OK, that's it! You will receive an email within the next 24 hours that will include a link to the member portal. You'll use your username and password from your account creation email to log in to your account. When you log in to the web portal, you'll be able to review, print and download all of your important documents. You'll also be able to print temporary ID cards to use until you receive your official ID cards in the mail, in approximately 7-10 business days. If you do not have access to the internet, please call (855) 351-7535 to request hard copies of your fulfillment materials. If you have any questions or need any assistance, please call (855) 351-7535.

By enrolling in this Health Depot Association (HD) Membership Plan you are agreeing to receive your membership materials (including instruction guides and ID cards) via email in addition to important notifications regarding your membership. You agree to the electronic insurance transaction and delivery of your policy(s) and related documents electronically. By choosing secure electronic delivery of your policy, Chubb will not send policy paper or related documents by regular mail except those which are required by law to be provided in a paper format. There is no fee to receive your Chubb policy(s) or related documents electronically. Chubb will provide your policy(s) or related documents via a PDF download available online. At any time, you can: change your email address; request a paper document; and unenroll from electronic delivery of your policy and related documents. You do not need any special software to open your secure electronic Chubb documents, just a personal computer with an Adobe PDF Reader. Where required by law, customer privacy policies will be attached to your insurance policy. By choosing to receive your policy(s) and related documents electronically, you agree to receive and acknowledge receipt of Chubb privacy policy notices electronically. Do you agree to electronically delivery of your insurance documents? This will conclude the verification. Thank you for your time and welcome to the Health Depot Association.