



EMPLOYEE CONSENT / AGREEMENT

Consent: I consent to any physician, hospital, clinic, pharmacy, medical or medically related facility, insurance company, or health information repository to give to American Community Mutual Insurance Company, its legal representatives or its reinsurers, any information, record or knowledge of the health of any persons proposed for insurance to carry out treatment, payment or health care operations. This consent includes information about drug and alcohol abuse and psychiatric conditions but does not provide for the release of psychotherapy notes. A photographic copy of this consent shall be as valid as the original for 24 months from the date below. I know that I, or my authorized representative may request and am entitled to receive a copy of this consent.

I acknowledge that I have been provided with a Notice of Your Privacy Rights, which provides a complete description of how my protected health information may be used or disclosed.

Disclosures: I understand no insurance exists unless and until my employer received notification in writing from American Community's Home Office indicating coverage for me and my dependents and the effective date. If, prior to such notification, anyone applying for coverage under the attached application consults a doctor, is hospitalized or has a change in health, I agree to inform American Community immediately. I understand that the agent does not have the authority to vary or waive any of the provisions of the application nor any provisions, terms or conditions of any other forms or materials supplied by American Community, nor bind American Community to any promise of coverage.

Representations: I represent that all statements and answers are true and complete to the best of my knowledge. I understand and agree that omissions, misrepresentation or misstatements may be used to deny a claim or terminate coverage if such information materially affects the degree of risk. **Any person who, with intent to defraud, submits an application or files a claim containing a false statement may be guilty of insurance fraud.**

Signature of Key Applicant
or personal representative

Relationship to applicant or representative's
authority to act for applicant

Date