SUPPLEMENTAL AFFIDAVIT OF ROBERT HEISSE

STATE OF TENNESSEE)
)
COUNTY OF DAVIDSON)

I, Robert Heisse, being duly sworn, hereby depose and aver as follows:

1. I am employed as a Fraud Investigator by the Insurance Division of the Department of Commerce and Insurance of the State of Tennessee ("Division") and have served in that capacity for approximately four years. In my position with the Division, I am responsible for investigating certain matters assigned to me. I also maintain the custody of documents obtained by the Division for the investigations that I have been assigned. I have been employed with the State of Tennessee since 1995. Before working as a Fraud Investigator for the Insurance Division, I was a Credit Union Examiner for the Department of Financial Institutions from December 2004 to March 2006. I was an investigator for the Securities Division of the Department of Commerce and Insurance for approximately six years from January 1998 to December 2004 and an examiner for the Registration Section of the Securities Division for approximately three years. I hold a Bachelor of Science degree in Public Administration and a Master of Business Administration degree from the University of Tennessee at Martin. I have had extensive training in financial investigations from the National White Collar Crime Center. In 2005, I successfully completed the new examiner training program conducted by the National Credit Union Administration. Also, I am a Certified Fraud Examiner and member of the Association of Certified Fraud Examiners. I am currently the investigator assigned to the matter of the American

Trade Association, LLC (ATA LLC), American Trade Association, Inc. ("ATA"), Smart Data Solutions, LLC ("SDS"), Bart Posey ("Posey") and others. All of the knowledge I have obtained about the activities of ATA LLC, ATA and SDS and the persons and entities affiliated with ATA LLC, ATA and SDS have been obtained over the course of my investigation.

2. In or around October 2008, I was assigned to investigate ATA LLC, ATA, SDS, and Posey for potential violations of Tennessee insurance law. This is a supplement to my affidavit filed as an exhibit

3. As of March 26, 2010, I have been conducting an investigation of activities of SDS and ATA at their offices located at 4676 Highway 41 North, Springfield, Tennessee 37172 and 400 Memorial Blvd., Springfield, Tennessee 37172.

4. Based on information obtained at the offices of SDS and ATA, SDS and ATA were engaged in marketing and selling health insurance. Sales and marketing material were found, as well as, evidence of marketing activities. True and correct copies of such marketing materials are attached hereto as **Exhibit 1**.

5. I found a sales script in an email between Richard H. Bachman and an outside marketer. The sales script told the marketer how to answer questions concerning the sales of health insurance, how to address the fact there was no insurance carrier, and what to say if the marketer was not a licensed insurance agent. A true and copy of the email from Richard H. Bachman's ("Bachman") computer containing the sales script is attached at **Exhibit 2**.

6. In the ATA office at 400 Memorial Blvd., Springfield, Tennessee 37172, I discovered sales enrollment packets prepared to be sent to people from several

states. Some the sales enrollment packets were addressed to individuals in states which have issued Cease and Desist Orders against ATA, including Kansas, Missouri, Florida, Michigan, Illinois, as well as, Tennessee. ATA membership and health benefit cards were among the items ready to be mailed. The health benefit cards had an effective date of April 1, 2010. A True and correct copy of a health benefit card contained in an enrollment pack is attached as **Exhibit 3**.

7. The sales enrollment packets that were evidently ready to be mailed out contained sales material and policy information from Americare Health and ATA. A booklet entitled "2010 Open Enrollment Information" contained an enrollment form and information concerning the health coverage, as well as, other benefits. The welcome letter stated the member would receive association medical benefits through ATA in association with Americare Health. There were also sales enrollment packets which stated the member received benefits through ATA alone. The sales enrollment and membership cards packets were being printed at the ATA office utilizing heavy bonded paper stock and materials to print the membership cards. True and correct copies of the booklets contained in the enrollment packets re attached as **Exhibit 4**.

8. In Bachman's office, I discovered incorporation documents for American Trade Association, Inc. formed in Robertson County and filed with the Secretary of State's Office on March 19, 2010 to be a Tennessee domestic non-profit corporation. True and correct copies of such incorporation documents are attached as **Exhibit 5**.

9. In Bachman's office, I also discovered evidence of the formation of a new non-profit corporation, to be located at 400 Memorial Blvd. in Springfield, Tennessee. The name on the Secretary of State Office's formation form (SS-4418) for this non-profit corporation was the Great American Benefit Association, Inc. A True and correct copy of the SS-4418 is attached as **Exhibit 6**.

10. In Richard Waltz's office, located at 400 Memorial Boulevard, Springfield, Tennessee 37172 I discovered a document entitled the "Compensation Check Audit Report" ("Report"). In the Report, certain SDS employees were listed as sales people and ATA Marketing was listed as a broker. Also, some SDS employees received checks from ATA which were for commissions. A True and correct copy of the Report is attached as **Exhibit 7**.

11. In the ATA/SDS office at 4676 Highway 41 North, Springfield, Tennessee 37172, I discovered mail addressed to Americare Health from a resident of Texas concerning an unpaid claim. A True and correct copy of the envelope is attached as **Exhibit 8**.

12. In Posey's office I discovered a letter with an attached subpoena, dated February 11, 2010, from the United States Department of Labor investigating whether ATA has violated or is about violate any provision of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1134(a)(1). The letter was addressed to Mr. Obed Kirkpatrick, Mr. Bart Posey, ATA and SDS at 4676 Highway 41 North, Springfield, TN 37172. The subpoena directed that personal appearance would not be required provided that the requested documents are

provided on or before March 1, 2010. A True and correct copy of the letter and the subpoena are attached as **Exhibit 9**.

FURTHER AFFIANT SAITH NOT.

Robert Heisse

SWORN TO AND SUBSCRIBED before me on this 30th day of March, 2010.

Notary Public

My Commission Expires: 11/7/12

JUDY L. JORDAN
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY, TENN.
My Commission Expires NOV. 7, 2012

American Trade Association

Major medical rates

Member only 364.21

Member spouse 665.00

Member family 856.00

AMERICAN TRADE ASSOCIATION RATES (10-5-09)

	500	1000	2500	5000	7500
MEMBER ONLY	185	235	195	260	285
MEMBER/ SPOUSE	275	330	340	390	440
MEMBER/CHILDREN	275	330	340	390	440
MEMBER/ FAMILY	330	405	350	470	525

CRITICAL ILLNESS $5000 PLAN

	18-49 YEAR OLDS		50-64 YEAR OLDS	
	NON TOBACCO	TOBACCO	NON TOBACCO	TOBACCO
MEMBER ONLY	13	18	20	33
COUPLE	15	22	25	40
FAMILY	20	35	33	60

CRITICAL ILLNESS $25,000 PLAN

	18-49 YEAR OLDS		50-64 YEAR OLDS	
	NON TOBACCO	TOBACCO	NON TOBACCO	TOBACCO
MEMBER ONLY	18	29	32	65
COUPLE	25	38	40	80
FAMILY	35	55	60	120

American Trade Association

JAIRED [redacted],

THANK YOU FOR YOUR MEMBERSHIP TO THE AMERICAN TRADE ASSOCIATION!! BELOW ARE YOUR MEMBERSHIP AND HEALTH BENEFIT CARDS.

PLEASE CALL US AT 800-591-6764 FOR ANY QUESTIONS.

American Trade Association

Member Name: JAIRED [redacted]
Member ID: 16995C4[redacted]

PPO PLAN
OV CO-PAYS $25

Group No: 40 **Effective Date:** 4/1/2010
Coverage Type: MEMBER + SPOUSE

DIATRI

American Trade Association

Member Name: JAIRED [redacted]
Member ID: 16995C4[redacted]

PPO PLAN
OV CO-PAYS $25

Group No: 40 **Effective Date:** 4/1/2010
Coverage Type: MEMBER + SPOUSE

DIATRI

American Trade Association

RANDI [redacted],

THANK YOU FOR YOUR MEMBERSHIP TO THE AMERICAN TRADE ASSOCIATION!! BELOW ARE YOUR MEMBERSHIP AND HEALTH BENEFIT CARDS.

PLEASE CALL US AT 800-591-6764 FOR ANY QUESTIONS.

American Trade Association

Member Name: PPO PLAN
RANDI [redacted] OV CO-PAYS $25
Member ID: 12438M4[redacted]

Group No: 29 **Effective Date:** 4/1/2010
Coverage Type: MEMBER ONLY

DIATRI Quest Diagnostics

American Trade Association

Member Name: PPO PLAN
RANDI [redacted] OV CO-PAYS $25
Member ID: 12438M4[redacted]

Group No: 29 **Effective Date:** 4/1/2010
Coverage Type: MEMBER ONLY

DIATRI

American Trade Association

DAVID [redacted],

THANK YOU FOR YOUR MEMBERSHIP TO THE AMERICAN TRADE ASSOCIATION!! BELOW ARE YOUR MEMBERSHIP AND HEALTH BENEFIT CARDS.

PLEASE CALL US AT 800-591-6764 FOR ANY QUESTIONS.

American Trade Association

Member Name: DAVID [redacted]
Member ID: 06255R1[redacted]

PPO PLAN
OV CO-PAYS $25

Group No: 29 **Effective Date:** 4/1/2010
Coverage Type: MEMBER + FAMILY

DIATRI

American Trade Association

Member Name: DAVID RUSSELL
Member ID: 06255R[redacted]

PPO PLAN
OV CO-PAYS $25

Group No: 29 **Effective Date:** 4/1/2010
Coverage Type: MEMBER + FAMILY

DIATRI

American Trade Association

JAMES [redacted],

THANK YOU FOR YOUR MEMBERSHIP TO THE AMERICAN TRADE ASSOCIATION!! BELOW ARE YOUR MEMBERSHIP AND HEALTH BENEFIT CARDS.

PLEASE CALL US AT 800-591-6764 FOR ANY QUESTIONS.

American Trade Association

Member Name:
JAMES [redacted]
Member ID: 12231B7[redacted]

PPO PLAN
OV CO-PAYS $25

Group No: 40 **Effective Date:** 4/1/2010
Coverage Type: MEMBER ONLY

DIATRI

American Trade Association

Member Name:
JAMES [redacted]
Member ID: 12231B7[redacted]

PPO PLAN
OV CO-PAYS $25

Group No: 40 **Effective Date:** 4/1/2010
Coverage Type: MEMBER ONLY

DIATRI

EFF 1-11-2010

NO TALKING TO ANY ONE IN THE FOLLOWING STATES!!

- OKLAHOMA
- NORTH CAROLINA
- MASSACHUSETTS
- CONNECTICUT
- INDIANA
- WASHINGTON STATE

NO NEW ENROLMENTS ...

CLAIMS, PRE EX MEMBERS, ARE OK TO TALK TO

NO UPGRADES

American Trade Association

400 MEMORIAL BLVD SPRINGFIELD, TN 37172

Member Name _____

Address _____

City _____

State _____

Zip Code _____

Telephone _____ Email _____

Monthly premium _____

Coverage for
- Member Only _____
- Member /Spouse _____
- Member/Children _____
- Member/Family _____

Please select your payment choice.

☐ Dues to be drafted monthly
- Name of Bank _____
- Name on Bank Account _____
- Routing Number (9 digits) _____
- Account Number _____

☐ Credit Card Name on Account_____

Card Type _____ Acc Number _____
Exp Date _____
CVV Code _____

***Date to be drafted_____

***Please note if draft date falls on the weekend, your account will be drafted the following business day.

Member's Signature _____ Date _____

Please fax to 866-512-6464, or mail to the address above. For assistance or questions call us at 800-591-6764.

For SDS use only:

Enrollment Center	Approved
Effective Date	Billing Status/Date
Current Week	Updated System
Previous Account Draft	Next Billing schedule
Notations:	

American Trade Association

1-12-10

Re: Health Benefits

Dear Sir:

The American Trade Association Inc has been notified by the marketing company that originally sold you the health benefits offered through the association that it intends to move the block of business to a new carrier and administrator. We do not know who the new carrier or administrator will be or what description will be on your draft just know that after 12-31-09 any draft will be for the new carrier and not the ATA.

Please be aware that this move may in fact change both your benefit levels, rates and definitely will eliminate the additional benefits offered through the association. These will include loss of the $25,000 accident rider you currently have as an association benefit plus access to the Peoples Choice Benefits which include discount, dental, vision, hearing, discount vitamins as well as the TeleDoc program.

Additionally your insured prescription plan through Express Scripts will also be terminated. The termination effective date will be 2-1-10. All claims incurred prior to that date should be continued to be sent to SDS for processing and payment.

If you would like to speak with one of our representatives about continuing your current benefits potentially at the same or a lower rate or consider upgrading your benefits please call our office directly at 800-546-7405.

Best Regards

RD WT

Richard Waltz
American Trade Association, Inc
400 Memorial Blvd
Springfield, TN 37172

EFF 1-11-2010

NO TALKING TO ANY ONE IN THE FOLLOWING STATES!!

- OKLAHOMA
- NORTH CAROLINA
- MASSACHUSETTS
- CONNECTICUT
- INDIANA
- WASHINGTON STATE

NO NEW ENROLMENTS ...

CLAIMS, PRE EX MEMBERS, ARE OK TO TALK TO

NO UPGRADES

American Trade Association

400 MEMORIAL BLVD SPRINGFIELD, TN 37172

Member Name _____

Address _____

City _____

State _____

Zip Code _____

Telephone _____ Email _____

Monthly premium _____

Coverage for
- Member Only _____
- Member /Spouse _____
- Member/Children _____
- Member/Family _____

Please select your payment choice.

☐ Dues to be drafted monthly
- Name of Bank _____
- Name on Bank Account _____
- Routing Number (9 digits) _____
- Account Number _____

☐ Credit Card Name on Account_____

Card Type _____ Acc Number _____
Exp Date _____
CVV Code _____

***Date to be drafted_____

***Please note if draft date falls on the weekend, your account will be drafted the following business day.

Member's Signature _____ Date _____

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For SDS use only:

Enrollment Center	Approved
Effective Date	Billing Status/Date
Current Week	Updated System
Previous Account Draft	Next Billing schedule
Notations:	

American Trade Association

1-12-10

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If you would like to speak with one of our representatives about continuing your current benefits potentially at the same or a lower rate or consider upgrading your benefits please call our office directly at 800-546-7405.

Best Regards

RD WT

Richard Waltz
American Trade Association, Inc
400 Memorial Blvd
Springfield, TN 37172

AFFIDAVIT OF MEMBER
REQUEST FOR CANCELLATION OF MEMBERSHIP

I, _____, of the City of _____, State of

_____, residing at _____,

being duly sworn, certify and affirm that:

1. **I wish to cancel my membership in the American Trade Association effective on _____, 20____**

   My plan currently is Member only _____ Member/Spouse _____
   Member/Children _____ Member/Family _____

2. **I further certify and affirm that the information appearing on this document is true and correct to the best of my knowledge and belief.**

Reason for cancellation: _____

_____

_____

Date: _____

By my hand is sworn: _____ **(Signature)**

Please Print: _____

Return via mail to: SDS 4676 Hwy 41 N; Springfield, TN 37172 or fax to 615-382-9594 or 800-546-7402 or email to Courtney Hulsey chulsey@sdsfirst.com

This is a cancellation request. Cancellation requests will be processed as received by SDS. If your recurring draft occurs prior to the termination date requested your coverage will end on the last day of the month coverage had been paid for.

AFFIDAVIT OF MEMBER
REQUEST FOR CREDIT OR REFUND

I, _____, of the City of _____, State of

_____, residing at _____,

being duly sworn, certify and affirm that:

1. I have paid through automatic account debiting the dollar amount for which I am requesting a refund.
2. The dollar amount requested did clear my financial institution and has irretrievably removed from my possession.
3. The said dollar amount has NOT been refunded, or credited previously by any other source in any manner.
4. I will not attempt further/additional collection of the funds by any other source in any manner.
5. The debit transaction was not originated with fraudulent intent, and the signature below is my own proper signature.
6. I further certify and affirm that the information appearing on this document is true and correct to the best of my knowledge and belief.

Dollar Amount Requested: _____

Request to Cancel: ☐ YES OR ☐ NO

Reason for cancellation: _____

_____

_____

Financial Institution Statement Attached: ☐ YES OR ☐ NO

Name on Account: _____

Date: _____

By my hand is sworn: _____ (Signature)

Please Print: _____

Return via mail to: SDS 4676 Hwy 41 N; Springfield, TN 37172 or fax to 615-382-9594 or 800-546-7402 or email to Courtney Hulsey chulsey@sdsfirst.com

Any attempt to collect undue funds will be considered a fraudulent act and this document may be used as evidence to that act.

This is a refund request. Refund requests will be assessed individually and refunds will be provided in accordance with membership benefit guidelines.

CERTIFICATE OF GROUP MEDICAL PLAN COVERAGE

IMPORTANT - KEEP THIS CERTIFICATE. This certificate is evidence of your coverage under this plan. Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems.

AMANDA C RUBIZHEVSKY
330 S. BARRINGTON AVE.
#309
BRENTWOOD, CA 90049

1. Date of this certificate: Mar 22 2010

2. Name of group medical plan: ATA American Trade Association

3. Name of participant: AMANDA C RUBIZHEVSKY

4. Identification number of participant: 06653R50692

5. Name of dependent to whom this certificate applies: none

6. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate:
   ATA American Trade Association
   4676 HIGHWAY 41 NORTH
   SPRINGFIELD, TN 37172

7. For further information call: (615)-382-9595

8. If the individual(s) identified in line 3 and line 5 has at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here ___ and skip line 9.

9. Date waiting period or affiliation period (if any) began: 08/01/2009

10. Date coverage began: 08/01/2009

11. Date coverage ended: _____ as of 12:01 AM (or check if coverage is continuing as of the date of this certificate: X)

Note: Separate certificates will be furnished for each covered participant and their dependents.

Statement of HIPAA Portability Rights

IMPORTANT - KEEP THIS CERTIFICATE. This certificate is evidence of your coverage under this plan. Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems.

PREEXISTING CONDITION EXCLUSIONS. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." A preexisting condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

-> Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in another plan.

RIGHT TO GET SPECIAL ENROLLMENT IN ANOTHER PLAN. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

-> Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

PROHIBITION AGAINST DISCRIMINATION BASED ON A HEALTH FACTOR. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

RIGHT TO INDIVIDUAL HEALTH COVERAGE. Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

* You have had coverage for at least 18 months without a break in coverage of 63 days or more;
* Your most recent coverage was under a group health plan (which can be shown by this certificate);
* Your group coverage was not terminated because of fraud or nonpayment of premiums;
* You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
* You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

-> Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

SPECIAL INFORMATION FOR PEOPLE ON FMLA LEAVE. If you are taking leave under the Family and Medical Leave Act (FMLA) and you drop health coverage during your leave, any days without health coverage while on FLMA leave will not count toward a 63-day break in coverage. In addition, if you do not return from leave, the 30-day period to request special enrollment in another plan will not start before your FMLA leave ends.

-> Therefore, when you apply for other health coverage, you should tell your plan administrator or health insurer about any prior FMLA leave.

STATE FLEXIBILITY. This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

FOR MORE INFORMATION. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: http://www.dol.gov/ebsa, the DOL's interactive web pages - Health Elaws, or http://www.cms.hhs.gov/hipaa1.

American Trade Association

JAMES MCMILLEN,

THANK YOU FOR YOUR MEMBERSHIP TO THE AMERICAN TRADE ASSOCIATION!! BELOW ARE YOUR MEMBERSHIP AND HEALTH BENEFIT CARDS.

PLEASE CALL US AT 800-591-6764 FOR ANY QUESTIONS.

American Trade Association

Member Name: JAMES MCMILLEN
Member ID: 02892M28974

PPO PLAN
OV CO-PAYS $25

Group No: 112 **Effective Date:** 4/1/2010
Coverage Type: MEMBER ONLY

DIATRI Quest Diagnostics

American Trade Association

Member Name: JAMES MCMILLEN
Member ID: 02892M28974

PPO PLAN
OV CO-PAYS $25

Group No: 112 **Effective Date:** 4/1/2010
Coverage Type: MEMBER ONLY

DIATRI Quest Diagnostics

To find a PPO provider, log onto www.myatabenefits.com or
Call 800-591-6764
For customer service, processing and claim inquiries, call 800-591-6764

Mail Medical Claims To:
SDS
4676 Hwy 41 N.
Springfield, TN. 37172

SDS provides administrative services only, and assumes no financial risk for claims.

This card does not guarantee coverage. To verify benefits, eligibility, claim status or find a provider, call 800-591-6764

To find a PPO provider, log onto www.myatabenefits.com or
Call 800-591-6764
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PPO PLAN
OV CO-PAYS $25

Group No: 112 **Effective Date:** 4/1/2010
Coverage Type: MEMBER ONLY

DIATRI

Quest Diagnostics

Administrative Office
XXX

NEW CARRIER

Dear Member:

Thank you for choosing to become of a member of the XXX and deciding to use our medical benefit product underwritten by NEW CARRIER. The best way we know to say thank you is to provide you with world class customer service and support. That is something we will strive to do each and every day through our relationship with XXX. our third party administrator. Your monthly dues draft will either reflect their name or reference "healthplan" on your bank statement as our representative and third party administrator. There are four draft weeks per month. For example if you are drafted the second week of the month the first time you are drafted your renewal week will always be the second week of the month going forward. The draft will normally be done on the Tuesday of that week and should show up in your account on Tuesday through Friday of that week each month as long as you are a member

The details in this letter and the documents included in this packet are very important pieces of information. We recommend you put them in a safe place so that you can refer to them whenever necessary. Included in this packet is everything you will need to get the most out of your benefit program. You have made a smart purchase and our goal is to help you use it wisely.

Included in this packet are the following items and information:

- Your medical Indemnity Identifications Cards
- Notice of Privacy Policy
- Your Certificate of Medical Benefits

Your Certificate of medical benefits includes the details of the level of benefit you have purchased. Please review it and if you have any questions now or in the future please contact customer service at the above number directly.

Use your Medical Indemnity Plan ID cards whenever you incur a claim. The information on it will help you and your provider understands the general coverages and will assist in filing a claim.

We will send you a copy of the explanation of benefits we send to your provider when we process one of your claims. It will help you understand how your benefits were paid and if there is a balance due the provider. This balance will be your responsibility to pay.

Information and records submitted for this coverage and any information received by XXX from your providers will be kept in complete confidence and privacy in compliance with all HIPAA Regulations.

If you ever have a question regarding your coverage or want to check on the status of a claim you have submitted, call XXX at 1-800-XXX-XXXX. You will be connected with a member of our Customer Care Team who will be able to answer your questions.

We hope you find this information useful and we appreciate your business. We promise to do everything possible to demonstrate that. If you have any questions, please give us a call and let us help.

Thank you,

You're XXX Customer Care Team

NEW CARRIER

NOTICE OF PRIVACY POLICY

Information Only – No Response Necessary

Protecting your privacy is important to us. We want you to understand what information we collect and how we use it. We collect and use "nonpublic personal information" in order to provide our customers with a broad range of financial products and services as effectively as possible. We treat nonpublic information in accordance with our Privacy Policy.

What Information We Collect and From Whom we collect it

We may collect nonpublic information about you from the following sources:

- Information we receive from you on applications or other forms;
- Information about your transactions with us, our affiliates, or others; and
- Information we receive from nonaffiliated third parties, including consumer reporting agencies.

"Nonpublic information personal information" is nonpublic information about you that we obtain in connection with providing a financial product or service to you.

What Information we Disclose and to whom we disclose it

We do not disclose any nonpublic information about you to either our "affiliates" or non-affiliates without your express consent, except as permitted by law. We may disclose the nonpublic personal information we collect, as described above, to persons or companies that perform services on our behalf and to other financial institutions with which we have joint marketing agreements.

Our "affiliates" are companies which we share common ownership and which offer life and health insurance and other insurance products.

You're Right to Verify Accuracy of Information we collect

Keeping your information accurate and up to date is very important to us. You may access and correct nonpublic personal information about you that we collect except for information relating to claims or criminal or civil proceedings.

Our Security Procedures

We restrict access to your nonpublic personal information and only allow disclosures to persons and companies as permitted by law to assist in providing products and services to you. We maintain physical, electronic, and procedural safeguards to protect your nonpublic information. Should your relationship with us end, we will maintain and only disclose nonpublic information that we have about you in accordance with this Privacy Policy.

NEW CARRIER

This Certificate explains the Limited Group Hospital Indemnity Benefits that is underwritten by NEW CARRIER. Please read it closely to be familiar with your coverage.

Terms important in understanding the Certificate are defined in the Definitions section or in separate Certificate Provisions and are capitalized in this Certificate.

Important Notice – Benefits are payable as described in this Certificate for accidents or sickness that are incurred while the Covered person is covered under the Group Master Policy ("Policy")

The Policy under which this Certificate is issued may at any time be amended or canceled, as stated in its provisions. Such an action may be taken without the consent of or notice to any Covered Person. Dues are subject to periodic changes.

The benefits included under this Policy do not take the place of nor does it affect any requirements for coverage by Workers' Compensation or a similar type of insurance.

The benefits for Dependents described in this Certificate will be applicable to each of your Dependents only if you are a covered member and you have applied for coverage for each of your dependents. Such applications must be approved by Us, and the required dues paid for each dependent.

Policyholder: XXX

Governing Jurisdiction: XXX

Policy Number: XXX

Covered Member:

Certificate Number:

Effective Date:

Signed for the Company at Our Home Office to take effect on the Certificate Effective Date.

President

CERTIFICATE FOR LIMITED GROUP HOSPITAL INDEMNITY BENEFITS

LIMITED BENEFIT – READ YOUR CERTICATE CAREFULLY
NONPARTICIPATING – NO ANNUAL DIVIDENDS

Administrative Office

XXX

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DEFINITIONS

The defined terms below are subject to the provisions of the Policy and of this Certificate:

Accident or Accidental Injury: a sudden, unexpected and unintended injury:

- This is independent of any Sickness; and
- That is caused by or the result of external means; and
- That takes place while the Covered person's coverage is in force.

Active Service: You are:

- Performing in the usual manner all of the regular duties of Your occupation on a scheduled work day; or are able to perform your normal work schedule if currently not employed; and

You are said to be in Active Service on a day which is not a scheduled work day only if You would be able to perform in the usual manner all of the regular duties of Your occupation if it were a scheduled work day,

Amendment, Endorsement or Rider: Any form issued by Us which adds, modifies, changes or deletes any Policy or Certificate provisions or benefits.

Application or Enrollment Form: The form completed and signed to apply for this insurance coverage.

Calendar year or Year: The period from January 1 through December 31 of the same year.

Certificate: The document that describes your hospital indemnity benefits coverage.

Child: A child of Yours who is unmarried; under the age of 19; dependent upon you for more than 50% of his/her support and maintenance; who lives with You; and is:

- A natural Child; or
- A legally adopted Child or a Child who has been placed for adoption with you; or
- A stepchild or foster Child; or
- A child for whom You have been appointed legal guardian; or
- A Child not living with You, but for whom you are legally required to provide support.

"Child" also includes a Child who meets the criteria described above, but who is age 19 or older, if the Child is:

- A full-time student at an accredited educational institution, college, university, vocational institution, trade school, or secondary institution, and is under the age of 24; or
- Becomes incapable of self-support because of mental retardation or physical impairment while covered and prior to reaching the limiting age of a Child. The child must be dependent on You for support and maintenance. We must receive proof of incapacity within 31 days after coverage would otherwise terminate. Then, coverage will continue for as long as Your benefits stay in force and the Child remains incapacitated. Additional proof may be required from time to time, but no more often than once a year after the Child attains the age of 24.

The term "Child" does not include a child who engages in any employment or business for compensation, profit or gain for 30 or more hours per week, unless such child is a full-time student as described above.

Confinement or Confined: That period of time the Covered Person is admitted into a medical facility on an inpatient basis in excess of 23 hours. Confinement does not include that period of time during which a Covered person is in a Hospital emergency room, an observation room, or a freestanding surgical facility or outpatient facility. Successive Confinements separated by 30 days or less will be considered as one Confinement.

Covered Person: Any or all of the following: You, You're Spouse or Your Children, who has been accepted by Us for coverage.

Critical Illness: Any of the following conditions:

1. Cancer – A disease which is identified by the presence of a malignant tumor characterized by uncontrolled growth and spread of malignant cells, and the invasion of normal tissue. Cancer must be positively identified and diagnosed with histopathological conformation. Leukemia and Hodgkin's disease (except stage 1 Hodgkin's disease) will be considered Cancer.

- Cancer does not include
    - Pre-Malignant conditions or conditions with malignant potential;
    - Prostatic cancers which are histologically described as TNM Classification T1 (including T1 (a) or T1 (b), or of other equivalent or lesser classifications).

2. Skin Cancer – Basel cell epithelioma or squamous cell carcinoma. Skin cancer does not include malignant melanoma or mycosis fungoides.
3. Carcinoma in situ – Cancer that is diagnosed with histopathological confirmation and confined to the site of the origin without having invaded neighboring tissue.
4. Heart Attack [the death (infarction) of a portion of heart muscle as a result of inadequate blood supply. The diagnosis must be based on all of the following criteria:
    - a) Associated new electrocardiographic (EKG) changes consistent with Injury;
    - b) Elevation of Cardiac enzymes; and
    - c) Confirmatory imaging studies such as thallium scans, MUGA scans or stress echocardiograms.
5. Stroke – A cerebrovascular event resulting in permanent neurological damage, including infarction, hemorrhage or embolizations of brain tissue from an extracranial source. The diagnosis must be based on:
    - Documented neurological deficits; and
    - Confirmatory neuron-imaging studies

    Stoke does not include cerebral symptoms due to:
    - Transient ischemic attack (TIA);
    - Reversible neurological deficit;
    - Migraine;
    - Cerebral injury resulting from trauma or hypoxia; or
    - Vascular disease affecting the eye, optic nerve or vestubular functions.
6. End Stage Renal Failure – Chronic, irreversible failure of the function of both kidneys, such that a Covered person must undergo regular hemodialysis or peritoneal dialysis at least weekly.
7. Major Organ Transplant Surgery – A Covered person undergoing surgery as a recipient of a human to human transplant of a heart, lung, kidney or pancreas.

Dependent – Your Child or Spouse as defined by the Certificate

Disability or Disabled – The inability, due to an injury or sickness to perform all of the substantial and material duties of your regular occupation.

For a Dependent Child or Spouse: "Disabled" means the inability to perform a majority of the normal activities of a person of like age in good health.

Effective Date – The date coverage is in effect is shown on the Schedule of Benefits. The effective date will start at 12:01 AM at the main place of business of the Policyholder.

Evidence of Insurability – The correct and complete answers to the questions in the Application of Enrollment Form and medical history, if necessary, which may be used by Us to base Our acceptance of any proposed Covered person.

Grace Period – The period of 31 days allowed for each dues payment after the first dues are paid.

Group Master Policy or Policy: The complete contact of benefits, which includes the Policy as issued to the Policyholder, as well as any Certificates issued to covered members, including any Amendments, Endorsement, Riders, Applications or Enrollment Forms signed by the Policyholder and each member.

Policyholder – The entity named on the Cover Page of the Policy

Hospital – A licensed institution that has on its premises or in facilities available to the Hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly Licensed Physicians.

1. Laboratory, X-ray equipment and operating rooms where major surgical operations may be performed by licensed Physicians.
2. Permanent and full-time facilities for the care of overnight resident bed patients under the supervision of a licensed Physician.
3. 24-hour-a-day nursing service by graduate registered nurses; and
4. A patient's written history and medical records.

The term "Hospital" does not include any institution used by the Covered Person as:

1. A place for rehabilitation;
2. A place for rest, or for the aged;
3. A nursing or convalescent home;
4. A long term nursing unit or geriatrics ward; or
5. An extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

Immediate Family Member – You, Your Spouse, Child, mother, father, and brother, sister or other close family member of the Covered person.

Injury or Off-the-Job injury - An injury which is caused by an Accident, and does not occur while in the course of any legal or illegal occupation, activity or employment for pay, benefit or profit.

Member– The employee or member covered for these benefits and named on the Cover page of this Certificate.

Intensive Care Unit – A specially designated area of a Hospital that provides the highest level of medical care restricted to those patients who are critically ill or critically injured. It must be separate and apart from the surgical recovery room and other rooms, wards, or beds normally used for patient confinement. It must also:

1. Be provided with constant and continuous nursing care by nurses assigned to it on a full-time basis; and
2. Be under the full-time direction and/or supervision of either a Physician or a standing committee of the Hospital's medical staff; and
3. Contain special life saving equipment.

Intensive Care Unit includes: Intensive cardiac and coronary care units, neonatal intensive care units, and burn intensive care units if such units meet the conditions in this definition. This does not include any lesser treatment units.

Physician – A licensed practitioner of the healing arts who:

1. Performs only those services permitted by his or her license; and
2. Is not an immediate Family member.

Pre-Existing Condition – A Sickness or physical condition for which the Covered person:

1. Had treatment;
2. Incurred Expense;
3. Took medications; or
4. Received a Diagnosis or advice from a Physician.

During the 12 month period immediately before the Effective Date of the Covered Person's coverage.

The term "Pre-existing" will also include a condition that manifests itself in a way that would cause an ordinary prudent person to seek medical advice, diagnosis, care or treatment.

Schedule of Benefits or Schedule – The benefit schedule set forth in this Certificate.

Sickness – An illness or disease which first manifests itself while the Covered person's coverage is in force and is the direct cause of the loss.

Spouse – Your legally married Spouse named in the Application or Enrollment Form. If you are not legally married, "Spouse" may include your common law spouse if named in the Application or Enrollment Form and if legally recognized in the state in which you reside.

Testing Day – The day on which one or more diagnostic X-rays or laboratory tests are performed.

Waiting Period – The period of time from your date of membership that must expire before you are eligible to enroll for coverage, as specified in the Policyholder's Application.

We, Us, or Our – The Insurer that underwrites this coverage: Serve America, LTD

You, Your, or Yours – The Covered Person.

ELIGIBILITY AND EFFECTIVE DATE

Effective dates are shown on the Schedule of Benefits. Coverage will start on such date at 12:01 AM at the main place of business of the Policyholder. Effective dates for all persons added to coverage after this Certificate is issued will be shown on the Schedule of Benefits issued at the time of the addition.

Employer or Member Eligibility – To be eligible for insurance You must:

1. Meet eligibility requirements as selected on the Policyholder's Application;
2. Satisfactorily answer all eligibility and other questions on the Application or Enrollment Form and must provide evidence of Insurability satisfactory to us, if we ask for it; and
3. Be eligible to work. Either as a business owner, independent contractor, works for a small business or a member of a workers union.

Employee or Member Effective Date – Your benefits will take effect on the Effective Date of the Policy if:

1. You completed an Application or Enrollment Form on or before the effective date; and
2. You are in Active Service; and
3. Your first dues payment is paid and received by Us.

If you are not eligible for this coverage on the Policy effective date, Your coverage will take effect on the first day of the day which coincides with or next follows the date You first become eligible and are approved for coverage. Additionally, Your first dues payment must have been received by Us, and all provisions listed in the Employee or Member Eligibility provision above, must be met.

If you are disabled on what otherwise would be the effective date, Your coverage will be deferred until the first of the month following the date you cease to be disabled.

Dependent Eligibility – If Dependent coverage is available, A Dependent will be eligible for such coverage on the later of the following dates:

1. The day you become eligible for coverage; or
2. The day he/she first meets the definition of Dependent.

You may elect dependent coverage by:

1. Applying for Dependent coverage within 31 days of the date the dependent becomes eligible; and
2. Completing any required forms for payroll deduction or drafting of your account for payment

You must complete an Application for Enrollment of a Spouse or Child, and pay any required dues within 31 days of the date Your Spouse or Child meets these eligibility criteria. If such Application is not made within that 31 day period Your Spouse or Child will be considered a late enrollee and may be required to submit satisfactory Evidence of approved eligibility in order for coverage to become effective.

Any eligible Dependent who does not become a covered person on your effective date may be added to this Certificate subject to:

1. The Completion of an Application or Enrollment Form;
2. Satisfaction of any Evidence of eligibility requirements; and
3. Payment of any additional dues, if required.

If you and your spouse are both eligible as an employee or member, the Children may be covered as Dependents of either You or your Spouse but not both

Dependent Effective Date – The effective date of coverage for each eligible Dependent will be on the first day of the month that coincides with or next follows:

1. Our acceptance of the Application or Enrollment Form; and
2. Our receipt of the first dues payment.

However, if on such date Your coverage has not yet taken effect, the effective date for dependent coverage will be the same as your effective date.

If a Dependent is Disabled on the date coverage (with respect to that particular Dependent) would otherwise be in effect, the coverage for that Dependent will be deferred until the first of the month following cessation of Disability for that Dependent.

Newborn Child Effective Date – A newborn Dependent Child will become eligible for coverage automatically on the day he or she is born, so long as your coverage is in force on that date. Coverage includes premature babies, congenital defects and birth abnormalities. The Dependent newborn child's coverage will not continue past the 31 day period following the date of birth, unless:

1. You have notified Us by the end of the 31 day period of the addition of such newborn Child, and
2. You have paid any applicable additional dues.

BENEFIT PROVISIONS

Subject to the provisions of this certificate, and any maximum benefit limitations stated on the schedule of benefits, we will pay a benefit for a covered loss that occurs while the covered person is insured under the policy, subject to extension of Benefits Provision. Please see the Schedule of Benefits for the benefit amount details for each benefit listed below.

Daily In-Hospital Indemnity Benefit – If a Covered Person is confined in a hospital as a result of Accident or Sickness, We will pay the benefit amount per day shown on the schedule. Each day must include an overnight stay for which a Hospital charge is made. No benefit will be paid for any day the Covered Person is not under the regular care and attendance of a Physician.

Surgical and Anesthesia Indemnity Benefit – If a Covered Person undergoes a surgical procedure listed on the Table of Surgical Indemnity Benefits Schedule ("RBRVS), as a result of a covered Accident or Sickness, We will pay the 80% level of benefit shown on that Surgical table. We will also pay an additional 25% amount the surgical benefit amount, if shown on the Schedule of Benefits, for the administration of anesthesia per surgical visit by a Physician in connection with the surgery.

If two or more procedures are performed through the same incision or operative field, the benefit paid will be for only the procedure that has the larger benefit If more than one procedure is performed, but each through a separate incision or in the separate operative field, the amount payable will be the specified amount for the primary procedure plus 50% of the amount payable for all other surgical procedures performed.

Representative surgeries have been listed in the Surgical Table. We will pay all surgeries in accordance with that Surgical Schedule. With respect to surgical procedures that are not listed in the Surgical Schedule, We will pay an indemnity benefit that is consistent with similar procedures within the Surgical Schedule.

Outpatient Physician Officer Visit Indemnity Benefit – We will pay this benefit as shown on the Schedule for a physician office visit as a result of an Accident or Sickness.

Off-the-Job Accidental Injury Benefit - We will pay benefits for the actually charges incurred for a covered Accident up to the amount shown on the Schedule for each Covered Person, for x-rays used to diagnose an Accidental Injury and treatment of a covered accident by a Physician in the Physician's officer, clinic, or urgent care facility or Hospital emergency room. Treatment must be received within 72 hours of such Accident for benefits to be payable. For purpose of this benefit only, "actual charges" will mean the amount actually paid by or on behalf of the Covered Person and accepted by a Hospital or Physician for services provided.

EMERGENCY ROOM SICKNESS BENEFIT INDEMNITY BENEFIT – We will pay the benefit amount specified on the Schedule for Emergency room sickness or illness up to the number of visits shown as the maximum annual benefit.

DAILY IN-PATIENT MENTAL & NERVOUS INDEMNITY BENEFIT – We will pay the maximum daily benefit listed in the schedule of benefits for a member who is admitted into a rehabilitation facility for the treatment of mental and nervous disorders up to the maximum of 30 days per year benefit at a daily rate equal to the benefit listed on the schedule. The member must be under the care of a licensed physician

Wellness Indemnity Benefit – We will pay this benefit as shown on the Schedule for each Covered Person who has undergone the following: physical examinations, mammograms, Pap smears, immunizations, flexible sigmoidoscopy, prostate-specific antigen tests and blood screenings. Services must be under the supervision of or recommended by a Physician, and a charge must be incurred.

Intensive Care Indemnity Benefit – If a Covered Person is confined in an Intensive Care Unit as a result of Accident or Sickness, We will pay the benefit amount per day shown on the Schedule. Each day must include an overnight stay for which a Hospital charge is made. No benefit will paid for any day the Covered Person is not under the regular care and attendance of a Physician.

Benefits When There is a Break in Service – If a covered Person's coverage terminates for any reason, and such person is re-enrolled for coverage as either an employee/member or Dependent under this Policy or any other all benefits paid during the Calendar Year will be accumulated and applied towards the maximum benefit for the Calendar Year as described on the Schedule of Benefits, no matter how many times a Covered Person becomes insured under this or any other Transamerica Life Insurance Company Group Hospital Indemnity Insurance Policy.

Physical Examinations and Autopsy – We have the right to have a Covered Person examined by a Physician of Our choice as often as reasonably necessary while a claim is pending. We will pay for such examination. In case of death, we may request an autopsy where it is not forbidden by law.

Proof of Loss – Satisfactory written Proof of Loss must be given to Us at Our Administrative Office. In case of a claim for loss for which a period payment is provided contingent upon continuing loss, each satisfactory written Proof of Loss must be sent within 90 days after the termination of the period for which we are liable. For any other loss, proof must be sent within 90 days after the date of said loss. Satisfactory written proof of loss includes but is not limited to: itemized Physician or Hospital bills, and, with regard to Critical Illness benefits, the initial pathology report diagnosing a Critical Illness.

Failure to furnish such proof within such time will not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof and that it was furnished as soon as it was reasonably possible. In any event, the proof required must be given no later than one year from the date of loss, unless the claimant was legally incapacitated.

Time of Payment of Claims – benefits for a covered loss will be paid after We receive satisfactory written Proof of Loss.

EXCLUSIONS AND LIMITATIONS

With respect to all the benefits provided under this Certificate, no benefits will be payable as the result of:

1. There is a 6 month pre-existing exclusionary period unless the member shows proof of current creditable coverage provided at time of application. Maternity is covered like any other illness but will carry the same pre-existing exclusion time of 6 months prior to benefits for maternity being in place.
2. Suicide or any attempt thereof, while sane or insane;
3. Any Intentional self-inflicted Injury or Sickness;
4. Rest care or rehabilitative care and treatment (unless provided as a benefit on the Schedule of Benefits);
5. Immunization shots and routine examinations such as: physical examinations, mammograms, Pap smears, immunizations, flexible sigmoidoscopy, prostate-specific antigen tests and blood screenings (unless the Wellness Indemnity Benefit is shown the Schedule of Benefits);
6. Routine newborn care (unless covered under the Wellness Indemnity Benefit on the Schedule of Benefits);
7. The treatment of:
    a. Mental illness, functional or organic nervous disorder, regardless of cause (unless the Daily In-Patient Mental and Nervous Benefit is shown the Schedule of Benefits):
    b. Alcohol abuse or drug use, unless such drugs were taken on the advice of a Physician and taken as prescribed (unless the Daily In-Patient Drug and Alcohol Benefit is shown the Schedule of Benefits);
8. Participating in a riot, civil commotion, civil disobedience, or unlawful assembly;
9. Committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation;
10. Participation in:
    a. An organized contest of speed;
    b. Parachuting;
    c. Parasailing;
    d. Bungee Jumping; or
    e. Hang Gliding;
11. Air travel, except:
    a. As a fare-paying passenger on a commercial airline on a regularly scheduled route; or.
    b. As a passenger for transportation only and not as a pilot or crew member;
12. Any accident caused by the participation in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician or taken according to the Physician's instructions) or while intoxicated (intoxicated means that condition as defined by the law of the jurisdiction in which the Accident occurred);
13. Any procedure or treatment to change physical characteristics to those of the opposite sex and other treatment related to sex change;
14. The reversal of a tubal ligation or vasectomy;
15. Artificial insemination, in vitro fertilization, and test tube fertilization, including an relate testing, medications or Physician's services, unless required by law;
16. Any loss incurred while on active duty status in the armed forces (if You notify us of such active duty, we will refund any premiums paid for any period for which no coverage is provided as result of this exception.);
17. Accident or Sickness arising out of and in the course of any occupation for compensation, wage or profit OR expenses which are payable under Occupational Disease Law or similar law, whether or not application for such benefits has been made;
18. Air or ground ambulance transportation (unless the Ambulance Benefit is shown on the Schedule);
19. Routine eye examinations or fitting of eye glasses;
20. Hearing aids or fitting of hearing aids;
21. Dental examinations or dental care other than expenses resulting from an Accident;
22. Care or treatment of an Accident or Sickness not specifically provided for in this plan;
23. With respect to the Off-the-Job Accidental Injury Benefit only, charges that the Covered Person is not legally required to pay, or charges which would not have been made if this coverage had not existed; or
24. Treatment of an Accident or Sickness made necessary by or arising from war, declare or undeclared, or any act of war.

DUES

All dues are payable on or before the date they are due. You must pay any required contribution to the Policyholder.

We have the right to change the dues rates on any dues due in accordance with the terms of the Policy. If the rates are changed, We will give at least a 31-day advance written notice to the Policyholder. If an increase takes place on other than a dues due date, a pro rata dues for the increase will be due on the next dues due date. The pro rata dues will be for the period from the date of the increase to the next dues due date. If such dues are not paid when due the coverage will automatically be terminated as of the date the pro rate dues was due. Any partial payment of dues will be refunded.

If the dues increase because a change in benefits increase Our liability, dues rates may be changed on the date that Our liability is increased, without regard to any dues rate guarantee.

TERMINATION OF INSURANCE

Your insurance will cease on the earliest of:

1. The last day of the payroll deduction period during which You can cease to be eligible for coverage;
2. The end of the last period for which dues payment has been made to Us;
3. The date the policy terminates; or
4. The last day of the payroll deduction period during which You terminate employment.
5.

The Insurance on a Dependent will cease on the earliest of:

1. The date Your coverage terminates;
2. The end of the last period for which dues payment has been made to Us;
3. The date of the Dependent no longer meets the definition of Dependent; or
4. The date the Policy is modified so as to exclude Dependent coverage.

We will have the right to terminate the coverage of any Covered Person who submits a fraudulent claim under the Policy.

Extension of Benefits – Whenever termination of coverage under this section occurs due to the termination of Your employment or membership such termination will be without prejudice to:

1. Any Hospital Confinement which commenced while coverage was in force, with respect to Daily In-Hospital Indemnity Benefits; or
2. Any covered treatment or service for which benefits would be provided and which commenced while coverage was in force; provided, however, that the Covered Person is and continues to be Hospital Confine or Disabled.

Such Extension of Benefits will continue for up to the earlier of:

1. 30 days; or
2. The date on which the Covered Person is no longer disabled.

CLAIMS PROVISIONS

Claim Forms – Claims forms should be used for filing Proof of Loss. We will send such form to claimant within 15 days of receipt of notice of claim. If we fail to supply the proper claim forms within 15 days, You can give proof in writing, setting for the nature and extent of loss within the time stated in the Proof of Loss Provision.

Claims Procedure – Due Proof of Loss must be submitted to us at our administrative Office. You or a personal representative may obtain a claim form by calling Our toll-free telephone number listed on the Cover Page.

Notice of Claim – Written notice of claim must be given to Us at Our Administrative Officer, or to Our agent. Such notice should be made within 30 days after any loss covered by the Policy. If it is not reasonably possible to give notice within that time, the claim may not be denied or reduced due to delay.

Payment of Benefits – Benefits may be assigned to the provider(s) of such benefits. Otherwise, provided you send us proof of payment to the providers all benefits payable under the Policy will be paid to You. Accrued benefits that are not paid at Your death will be paid to Your estate. We may pay up to $1,000.00 of such benefit to one of Your relatives at Our discretion. Such payment fully discharges Us to the extent of the payment.

GENERAL PROVISIONS

Changes to this Certificate – Only Our President, Vice-President, Secretary or an Assistant Secretary may make any changes to this Certificate and then only in writing. No agent or Policyholder has authority to change the Policy of this Certificate or to waive any of its provisions. Any changes are subject to the laws of the governing jurisdiction.

Entire Contract – The entire Contract consists of the Policy, the Certificate, any attached Amendments, Endorsements, or Riders, the Policyholder's Application, Your Applications and any Enrollment forms.

Grace period – A grace period of 31 days will be allowed for each dues payment after the first dues are paid. Coverage will stay in force during this period. The coverage under the Policy and/or Certificate will terminate at the end of the Grace Period if the premium has not been paid. You must still pay all unpaid dues. This includes the dues due for the Grace Period.

If coverage is canceled on a dues due date and the dues have been paid through that date, the Grace period will not apply. If coverage is canceled during the Grace Period, you will be liable for any unpaid dues including the pro rata premium for that part of the Grace Period which coverage was in force. Benefits may be reduced by the amount of any due, but unpaid premium.

Legal Action – No legal action may be brought to recover under the Policy and or Certificate:

1. Within 60 days after proof of Loss has been furnished as required; or
2. More than three years from the time written Proof of Loss is required to be furnished.

Misstatement of Age – If the covered person's age has been misstated, the covered persons true age will be used to adjust the dues or adjust the benefits paid.

No Dividends Payable – This Certificate does not participate in the profits or surplus earnings of Our Company.

Right to Contest – We will not use any statement, except fraudulent statements, to void or reduce benefits after this Certificate has been in force during your lifetime for two years from the effective date of coverage. Any such statement would have to be in a signed form. This also applies to all riders. Any increase in benefit amounts would be subject to a new two year contestable period for the increased amount only.

All statements made are considered representations and not warranties. No such statement will be used in any contest, unless a copy of such statement has been furnished to you.

When Notice is Given to Us – Any notice to You will be sent to your last known address.

IMPORTANT INFORMATION TO POLICYHOLDERS

In the event you need to contact anyone about this policy for any reason please contact your agent. If you have additional questions you may contact the insurance company issuing this policy at the following address and telephone number:

XXX

All of the above information relates to the Limited Benefit Hospital Indemnity Policy issued to your Policyholder

The Association provides additional benefits which are described and outlined in the material you will receive. Please be aware that not all the Association benefits are underwritten and many are discount programs offered to you as a member of the Association.

SCHEDULE OF BENEFITS

MEMBER: CERTIFICATE NUMBER:

AGE AT ISSUE: DEPENDENT COVERAGE:

MEMBER EFFECTIVE DATE: DEPENDENT EFFECTIVE DATE:

ANNUAL MAXIMUM
BENEFIT LIMIT: NONE

BENEFIT COVERAGE

EFFECTIVE DATE:	TYPE OF COVERAGE PER COVERED PERSON
DAILY IN-HOSPITAL INDEMNITY AMOUNT BENEFIT AMOUNT PER DAY: MAXIMUM OF 30 DAYS PER CONFINEMENT	$1000
DAILY INDEMINITY BENEFIT FOR CONFINEMENT IN AN INTENSIVE CARE OR CRITICAL CARE IN-PATIENT ROOM BENEFIT AMOUNT PER DAY: MAXIMUM OF 15 DAYS PER YEAR PER MEMBER	$1000
IN-HOSPITAL & IN-PATIENT ADDITIONAL HOSPITAL INDEMNITY BENEFIT	$1000
SURGICAL AND ANESTHESIA INDEMINTY BENEFIT BENEFIT FOR SURGERY PER SURGICAL VISIT AS LISTED IN THE TABLE OF SURGICAL INDEMNITY BENEFIT SCHEDULE RBRVS:	80% OF RBRVS TO MAXIMUM OF $10,000
BENEFIT FOR ANESTHESIA PER SURGICAL VISIT	25% OF SURGERY BENEFIT
OUTPATIENT PHYSICIAN OFFICE VISIT INDEMNITY BENEFIT - BENEFIT AMOUNT PER OFFICE VISIT: MAXIMUM NUMBER OF OFFICE VISITS PER YEAR PER MEMBER:	$100 5
OFF-THE-JOB ACCIDENT INJURY BENEFIT MAXIMUM BENEFIT:	$100 DEDUCTIBLE $5000 MAX BENEFIT
OUTPATIENT DIAGNOSTIC X-RAY & LAB INDEMNITY BENEFIT BENEFIT AMOUNT PER VISIT PER MEMBER: CALENDAR YEAR MAXIMUM VISITS PER MEMBER:	$100 3
OUTPATIENT MENTAL HEALTH VISITS MAXIMUM NUMBER OF VISIT ANUALLY PER MEMBER	$100 20

EMERGENCY ROOM SICKNESS BENEFIT INDEMNITY BENEFIT	
BENEFIT AMOUNT PAID OER ER VISIT FOR SICKNESS OR ILLNESS:	$100
MAXIMUM NUMBER OF VISITS PER YEAR:	1
WELLNESS INDEMNITY BENEFIT	
BENEFIT AMOUNT PER VISIT PER MEMBER:	$100
MAXIMUM CALENDAR YEAR VISITS PER MEMBER:	1 MAX VISIT
DAILY IN-PATIENT MENTAL & NERVOUS INDEMNITY BENEFIT	
BENEFIT PER DAY OF CONFINEMENT IF MEMBER IS CONFINED IN A REHABILITATION FACILITY FOR MENTAL OR NERVOUS DISORDERS	$100 PER DAY
ANNUAL MAXIMUM BENEFIT:	30 DAYS
ACCIDENTAL DEATH (AD&D) LIFE POLICY WITH ACCIDENTALDEATH AND DISMEMBERMENT RIDER ATTACHED	
PER COVERED MEMBER BENEFIT:	$15,000

SCHEDULE OF BENEFITS

MEMBER: CERTIFICATE NUMBER:

AGE AT ISSUE: DEPENDENT COVERAGE:

MEMBER EFFECTIVE DATE: DEPENDENT EFFECTIVE DATE:

ANNUAL MAXIMUM
BENEFIT LIMIT: NONE

BENEFIT COVERAGE

EFFECTIVE DATE:	TYPE OF COVERAGE PER COVERED PERSON
DAILY IN-HOSPITAL INDEMNITY AMOUNT BENEFIT AMOUNT PER DAY: MAXIMUM OF 30 DAYS PER CONFINEMENT	$500
DAILY INDEMINITY BENEFIT FOR CONFINEMENT IN AN INTENSIVE CARE OR CRITICAL CARE IN-PATIENT ROOM BENEFIT AMOUNT PER DAY: MAXIMUM OF 15 DAYS PER YEAR PER MEMBER	$500
IN-HOSPITAL & IN-PATIENT ADDITIONAL HOSPITAL INDEMNITY BENEFIT	$500
SURGICAL AND ANESTHESIA INDEMINTY BENEFIT BENEFIT FOR SURGERY PER SURGICAL VISIT AS LISTED IN THE TABLE OF SURGICAL INDEMNITY BENEFIT SCHEDULE RBRVS:	80% OF RBRVS TO MAXIMUM OF $5,000
BENEFIT FOR ANESTHESIA PER SURGICAL VISIT	25% OF SURGERY BENEFIT
OUTPATIENT PHYSICIAN OFFICE VISIT INDEMNITY BENEFIT - BENEFIT AMOUNT PER OFFICE VISIT: MAXIMUM NUMBER OF OFFICE VISITS PER YEAR PER MEMBER:	$50 5
OFF-THE-JOB ACCIDENT INJURY BENEFIT MAXIMUM BENEFIT:	$100 DEDUCTIBLE $1000 MAX BENEFIT
OUTPATIENT DIAGNOSTIC X-RAY & LAB INDEMNITY BENEFIT BENEFIT AMOUNT PER VISIT PER MEMBER: CALENDAR YEAR MAXIMUM VISITS PER MEMBER:	$50 3
OUTPATIENT MENTAL HEALTH VISITS MAXIMUM NUMBER OF VISIT ANUALLY PER MEMBER	$50 20

Bart Posey

From: dale@df12.com
Sent: Monday, September 28, 2009 7:13 AM
To: posey bart
Subject: WW money

Bart:

No deposit was made.

Nathan is ready to cut us loose on this group. Bart, I am not making a presentation until this debt is paid. I offered up a discount last week. It was not taken. I want 10K in my bank by today. I want the other 5K in my bank by October 5th. (I am supposed to do a presentation on the plans October 6th.)

I put up the 25K with total faith and I want to be repaid with total faith.

If you guys do not want to do this, I understand. I will find somebody else to work with on it.

It is unfortunate that you are caught in the middle of this, but WW is lower than the bottom of the ocean in regards to this deal. I am not going to put one nickel in his pocket until I am repaid. Bart, you are my friend, but I am not going to do it.

Let me know what you plan to do. I am not moving off the money amounts or the timelines I set above.

DF

Bart Posey

From: wworthy35@comcast.net
Sent: Monday, February 11, 2008 11:03 AM
To: Bart
Subject: Re: Rates on new plans

Bart,

That is correct. I assume that you have deducted the 7% admin.

Please remember to add the 5% back for me somewhere.

Many thanks,

William

---------- Original message ----------
From: "Bart" <bposey@sdsfirst.com>

100	300	500	1000
28.37	43.93	60.28	97.78
48.71	77.66	108.20	176.23
45.91	70.33	96.10	155.42
66.43	104.40	144.45	234.73

William Please make sure that the above rates are correct and confirm back to me ASAP

Bart

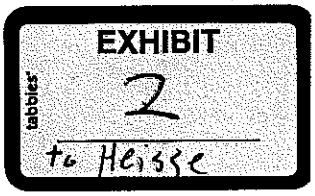
From: Eric
To: "Rick Bachman"
Cc: Jami Leslie
Subject: Our Sale Scripts...
Date: Thursday, September 03, 2009 10:52:47 AM
Attachments: ATA CS500 vs PPO5000 07.09.xlsx
ATA Health Script-New.docx

Rick,

We do not over sell our plans... I wanted to send you a copy of our sales script to see if you need for us to make any changes.

Thanks

Eric



Health Script

Benefits enrollment center this is _____. With whom am I speaking?

What state are you calling from? **Don't Sell: N.C.**

Are you looking for coverage for a single, couple, family or your employees?

Do you currently have coverage? – *(Important: Use facts to solidify your close!)*

No: Why! Lost job, too expensive, Dropped, Preexisting Condition?

Yes: What about your current coverage don't you like? How much does it cost?

Do you have an annual deductible? What is your co-pay?

Does you current coverage includes: Vision, Dental or Hearing?

Is there any history of heart attack, stroke, or cancer in the last year?"

You do qualify for the rate of _____. That's going to give you all the insured benefits that are listed there on the flyer: medical, dental, vision, chiropractic care, prescription drug coverage, emergency room coverage, and hospitalization.

This is a PPO network which means you do have the opportunity to choose your own doctors and hospitals. **We are a group insured benefit which means you have no annual deductible**. When you go to the doctor, hospital or ER your co-pay is $25. You simply show your card and the Doctor**. The plan is month to month; you can keep it as long as you need it there is no contract involved.** We a have very few cancelations, we pride ourselves in customer satisfaction.

So to start it's going to be the monthly premium plus the one time enrollment fee of $125. Once you become a member of the Association you're going to be placed with a top rated insurance carrier. You carrier will be determined by geographic location, employment status, pre-existing conditions, and number of dependants. You will receive a welcome packet from the association plus you're going to receive your benefits package which includes your ID cards and your insurance certificate with your primary underwriter included.

We do all of our billing by phone through automatic draft, the first payment will take place _____ and coverage will begin_____.

-Let's get started...How do you spell your name...

-Where do you want me to send your welcome packet...

-What's the first name that you would like to go onto the policy...

Who is the underwriter?

When you **join the association** will place you with a top rated insurance carrier.

There are a lot of determining factor with go into this process.

Some of the determining factors include:

Geographic location
Pre-existing conditions
Employment status
Number if dependants

I need to know who its underwritten by?

I understand you concern and as I stated earlier we are guaranteeing you will be placed with a top rated carrier.

What is most important is the coverage provided, the rating of the carrier and the amount you pay not the name of a carrier…

You will receive a welcome packet from the association plus you're going to receive your benefits packet which includes your ID cards and your insurance certificate with your primary underwriter included.

I know you're going to be satisfied…

We have very few cancelations…

If you **prefer to pay a premium**, for a name like Blue Shield than this may not be the correct product for you…

Unlike major medical we offer no annual deductibles….

Refer to: CS500 vs. PPO5000 flyer…

No Insurance Carrier will cover 100% of your health care needs!

Unlike Individual Health Plans (Major Medical)...We are a **Group Insured Benefit**!

We have no upfront fees or annual deductibles!

Let me give you a comparison for a healthy family of 5 (2 ADULTS AND 3 CHILDREN)

PROCEDURE	COST SAVER 500	BLUE SHIELD PPO 5000 80/20
COST:	$369.00 MONTHLY	$983.00 - EST. MOTHLY
ROUTINE DR VISIT:	***$25 AT TIME OF VISIT***	$40.00 CO-PAYMENT
INTENSIVE CARE:	NO DEDUCTIBLE	$5000 ANNUAL DED. + 20%
EMERGNCY ROOM:	$1,000	$5000 ANNUAL DED. + 20%
HOSPITILIZATION:	NO DEDUCTIBLE	$5000 ANNUAL DED. + 20%
RX DRUGS:	NO DEDUCTIBLE	$500 ANNUAL DED.

***The average cost of a routine Dr visit is $60-$80.**
You pay $25.00 at the time of office visit. Your carrier will negotiate with the provider to guarantee you the lowest possible rate.

Let's put things into perspective, we have no upfront costs associated with our program!

47% of the bankruptcies in the country we due to excessive medical bills!
25% of people with excessive medical bills have to get a 2nd mortgage or refinance!

Individual Health Plans have $5000 deductible's which need to be paid prior to receiving **Any Health Benefits- plus you are still responsible for 20% of your medical bills!**
Do you have $30,000 in your savings account?

In addition, our plan includes discounts on, perscriptions, vision, hearing, dental, lab, x-ray

From: Eric
To: "Rick Bachman"
Subject: Scripts: Who We Are.docx
Date: Thursday, September 03, 2009 12:09:15 PM
Attachments: ATA Who We Are.docx

Rick,

Another script for your approval...

Thanks

Eric

We are:

Superior Health Benefits or the Benefits Enrollment Center

The name of the association:

ATA - The American Trade Association - Not to be disclosed till after the sale!

- Established 23 Years - since 1986.

- Will appear on the member s bank statement ATA/SDS membership 800.591.6764

We are selling a membership to an association very much like:

AAA- Automobile Association of America

AARP- America Association of Retired People

Which among other benefits, does include Insured Health Benefits

Underwriting:

Depending on your geographic location, pre-existing conditions, employment status, age, number of dependants your coverage will be underwritten by a top rated insurance provider.

Important Notes:

If you are not a licensed insurance agent:

Say: ***Insured Benefits*** NOT ***Insurance***

Say: ***Coverage*** NOT ***Policy***

American Trade Association

HEATHER [redacted]

THANK YOU FOR YOUR MEMBERSHIP TO THE AMERICAN TRADE ASSOCIATION!! BELOW ARE YOUR MEMBERSHIP AND HEALTH BENEFIT CARDS.

PLEASE CALL US AT 800-591-6764 FOR ANY QUESTIONS.

American Trade Association

Member Name:
HEATHER [redacted]
Member ID: 12433C0[redacted]

PPO PLAN
OV CO-PAYS $25

Group No: 122 **Effective Date:** 4/1/2010
Coverage Type: MEMBER + SPOUSE

DIATRL

Quest Diagnostics

American Trade Association

Member Name:
HEATHER [redacted]
Member ID: 12433C0[redacted]

PPO PLAN
OV CO-PAYS $25

Group No: 122 **Effective Date:** 4/1/2010
Coverage Type: MEMBER + SPOUSE

DIATRL

Quest Diagnostics

EXHIBIT
3
To Heisse

To find a PPO provider, log onto www.myatabenefits.com or
Call 800-591-6764
For customer service, processing and claim inquiries, call 800-591-6764

Mail Medical Claims To:
SDS
4676 Hwy 41 N.
Springfield, TN. 37172

SDS provides administrative services only, and assumes no financial risk for claims.

This card does not guarantee coverage. To verify benefits, eligibility, claim status or find a provider, call 800-591-6764

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American Trade Association

2010
ATA MEMBER
BENEFITS

American Trade Association

Welcome To the American Trade Association

Thank you for choosing the ATA as your Association. We are pleased to offer you as a member of the Association, our health benefits. We know you have many choices when looking for the right type of benefits and services for you and your family, and we appreciate the trust that you have placed in us.

Association Benefits

This welcome kit is designed to acquaint you with the services and benefits offered to you as a member of the American Trade Association. As a member, you are eligible to take advantage of any of the ancillary benefits offered through your Association.

Keep in mind that the Association offers you several ways to understand your benefits and how they work for you and your family. First, included in this Welcome Kit you will find information regarding the health benefits plan that you have chosen. If you have any questions about the benefits, or how to make them best work for you, please feel free to contact our customer service center and speak to one of our knowledgeable staff members. Our Customer Service Staff are all trained professionals and are available from 8:00 AM central time until 5:00 Central time Monday through Thursday and 8:00 until 3:00 PM on Fridays. Emergency admissions are always approved and handled for verification purposes on the following work day.

1-800-591-6764
ATA Customer Service

Again, please know we appreciate your confidence in the ATA and look forward to a long and mutually beneficial relationship. Our goal is not just to meet your expectations, but to exceed them. Because your *approval* is on the line.

NOTICE OF PRIVACY POLICY

Information Only – No Response Necessary

Protecting your privacy is important to us. We want you to understand what information we collect and how we use it. We collect and use "nonpublic personal information" in order to provide our customers with a broad range of financial products and services as effectively as possible. We treat nonpublic information in accordance with our Privacy Policy.

What Information We Collect and From Whom we collect it

We may collect nonpublic information about you from the following sources:

- Information we receive from you on applications or other forms;
- Information about your transactions with us, our affiliates, or others; and
- Information we receive from nonaffiliated third parties, including consumer reporting agencies.

"Nonpublic information personal information" is nonpublic information about you that we obtain in connection with providing a financial product or service to you.

What Information we Disclose and to whom we disclose it

We do not disclose any nonpublic information about you to either our "affiliates" or non-affiliates without your express consent, except as permitted by law. We may disclose the nonpublic personal information we collect, as described above, to persons or companies that perform services on our behalf and to other financial institutions with which we have joint marketing agreements.

Our "affiliates" are companies which we share common ownership and which offer life and health benefits and other benefit products.

You're Right to Verify Accuracy of Information we collect

Keeping your information accurate and up to date is very important to us. You may access and correct nonpublic personal information about you that we collect except for information relating to claims or criminal or civil proceedings.

Our Security Procedures

We restrict access to your nonpublic personal information and only allow disclosures to persons and companies as permitted by law to assist in providing products and services to you. We maintain physical, electronic, and procedural safeguards to protect your nonpublic information. Should your relationship with us end, we will maintain and only disclose nonpublic information that we have about you in accordance with this Privacy Policy.

TABLE OF CONTENTS

This Certificate explains the Limited Group Hospital Indemnity Benefits. Please read it closely to be familiar with your coverage.

Terms important in understanding the Certificate are defined in the Definitions section or in separate Certificate Provisions and are capitalized in this Certificate.

Important Notice – Benefits are payable as described in this Certificate for accidents or sickness that are incurred while the Covered person is covered under the Group Master Policy ("Policy")

The Policy under which this Certificate is issued may at any time be amended or canceled, as stated in its provisions. Such an action may be taken without the consent of or notice to any Covered Person. Dues are subject to periodic changes.

The coverages made under this Policy do not take the place of nor does it affect any requirements for coverage by Workers' Compensation or a similar type of insurance.

The benefits for Dependents described in this Certificate will be applicable to each of your Dependents only if you are covered and you have applied for coverage for each of your dependents. Such applications must be approved by Us, and the required dues paid for each dependent.

Policyholder:	American Trade Association, Inc.
Governing Jurisdiction:	Indiana
Policy Number:	ATA51111
Insured:	
Certificate Number:	
Effective Date:	

Signed for the Company at Our Home Office to take effect on the Certificate Effective Date.

CERTIFICATE FOR LIMITED GROUP HOSPITAL INDEMNITY BENEFITS
PER OCCURRENCE PLAN
LIMITED BENEFIT – READ YOUR CERTICATE CAREFULLY
NONPARTICIPATING – NO ANNUAL DIVIDENDS

Administrative Office:
SDS, LLC
4676 Highway 41 North
Springfield, TN 37172
Customer Service: 1-800-591-6764
Facsimile: 1-615-382-9594

SCHEDULE OF BENEFITS
2500 PER OCCURRENCE PLAN

ELIGIBILITY REQUIREMENTS

An Eligible Person means a person in one of the following classes:

Class 1: All active and qualified members of the policyholder who are not eligible for any other employer/contractor sponsored health plan for which application and dues have been received.

Class 2: All eligible spouses and dependent children of Class 1 members for whom application and dues have been received.

ENROLLMENT PERIOD

An eligible person may only enroll within 31 days after Association membership begins and he becomes eligible.

BENEFIT AMOUNTS

The policy provides coverage only for the benefit amounts shown.

Class 1 & 2

Accidental Death Benefit	
Principal Sum	$10,000
Loss period	Loss within 365 days of date of the Accident
Medical Express Benefit – Accident and Sickness	
Maximum Benefit Amount	$2,500 Per Occurrence
Deductible	$300 Per Occurrence
Office Visit/Co-Pay Amount	$25.00 Co-Benefit up to $50 (No Deductible)
Coinsurance	80%
Benefit Period	52 Weeks
Outpatient Lab & X-ray Maximum Including Interpretation	$750 Per Occurrence
Emergency Room Deductible (Waived if due to an accident or results in admission to hospital)	$250 Per Visit
Additional In-Hospital Benefit (Payable after basic benefits exhausted)	
Maximum Benefit Amount	$400 Per Day
Maximum number of days	30 days Per Occurrence

2500 PER OCCURRENCE

DEDUCTIBLE	
Per Occurrence Deductible	$300.00
MAXIMUM BENEFIT	
Per Illness or Accident Maximum Benefit	$2,500.00
Additional In-Hospital Benefit (Payable after Basic Benefit is exhausted)	$400.00
HOSPITAL CARE	
Inpatient	Covered at 80% up to maximum*
Outpatient	Covered at 80% up to maximum*
PHYSICIAN OFFICE CARE	
Out-Patient Physician Visits	Covered at 100% up to maximum*
Out-Patient Physician Co-Pay/Max Amount	$25.00 Co-Pay paid to plan max
LAB/X-RAY/DIAGNOSTIC TESTS	
Lab/X-Ray/Diagnostic Tests (including interpretation)	Covered at 80% up to $750.00 Per Occurrence
OUTPATIENT INJECTIONS BENEFIT – MUST BE PERFORMED IN PHYSICIANS OFFICE.	$25 CO-PAYPER VISIT
BENEFIT AMOUNT PER VISIT	UP TO $100
MENTAL HEALTH	
Inpatient	Covered at 80% up to maximum*
ALCOHOL/DRUG REHABILITATION	
Inpatient	Covered at 80% up to maximum*
EMERGENCY CARE	
Emergency Room Deductible	$250.00 per Emergency Room Visit
Emergency Room	Covered at 80% up to maximum*
Emergency Room	Deductible waived if due to accident Or admitted to Hospital as result
Ambulance	Covered at 80% up to maximum*
OTHER MEDICAL SERVICES	
Home Health Care	Covered at 80% up to maximum*
Skilled Nursing Facility	Covered at 80% up to maximum*
Hospice	Covered at 80% up to maximum*
Physical Therapy	Covered at 80% up to maximum*
Durable Medical Equipment	Covered at 80% up to maximum*
SURGEON'S CARE	
Inpatient	Covered at 80% up to maximum*
Outpatient	Covered at 80% up to maximum*

PRESCRIPTIONS

Generic	$10 maximum member payment per 30 day supply
Brand	$50 maximum member payment per 30 day supply

Generic available through retail location or mail order. Brand is available through mail order only

PREFERRED PROVIDER NETWORK

Doctor or Facility of Your Choice	No discount Any discounts for using network providers passed on to you

PRE-EXISTING CONDITIONS

Pre-existing Condition Exclusions	Yes
If a condition is treated in the prior	12 months
No coverage for that pre-existing condition	12 months, unless the member has prior creditable coverage. Proof of coverage must be provided to SDS, LLC at time of application.
Pregnancy will be covered as any sick or illness	Pre-existing rule applies

*SUBJECT TO USUAL & CUSTOMARY CHARGES FOR MEDICALLY NECESSARY EXPENSES

DEFINITIONS

The defined terms below are subject to the provisions of the Policy and of this Certificate:

Accident or Accidental Injury: a sudden, unexpected and unintended injury:

- This is independent of any Sickness; and
- That is caused by or the result of external means; and
- That takes place while the Covered person's coverage is in force.

Active Service: You are:

- Performing in the usual manner, or able to perform all of the regular duties of Your occupation on a scheduled work day; and

You are said to be in Active Service on a day which is not a scheduled work day only if You would be able to perform in the usual manner all of the regular duties of Your occupation if it were a scheduled work day.

Amendment, Endorsement or Rider: Any form issued by Us which adds, modifies, changes or deletes any Policy or Certificate provisions or benefits.

Application or Enrollment Form: The form completed and signed to apply for this medical benefit coverage.

Calendar year or Year: The period from January 1 through December 31 of the same year.

Certificate: The document that describes your hospital indemnity coverage.

Child: A child of yours who is unmarried; under the age of 19; dependent upon you for more than 50% of his/her support and maintenance; who lives with you; and is:

- A natural Child; or
- A legally adopted Child or a Child who has been placed for adoption with you; or
- A stepchild or foster Child; or
- A child for whom You have been appointed legal guardian; or
- A Child not living with you, but for whom you are legally required to provide support.

"Child" also includes a Child who meets the criteria described above, but who is age 19 or older, if the Child is:

- A full-time student at an accredited educational institution, college, university, vocational institution, trade school, or secondary institution, and is under the age of 24; or
- Becomes incapable of self-support because of mental retardation or physical impairment while insured, and prior to reaching the limiting age of a Child. The child must be dependent on you for support and maintenance. We must receive proof of incapacity within 31 days after coverage would otherwise terminate. Then, coverage will continue for as long as your insurance stays in force and the Child remains incapacitated. Additional proof may be required from time to time, but no more often than once a year after the Child attains the age of 24.

The term "Child" does not include a child who engages in any employment or business for compensation, profit or gain for 30 or more hours per week, unless such child is a full-time student as described above.

Confinement or Confined: That period of time the Covered Person is admitted into a medical facility on an inpatient basis in excess of 23 hours. Confinement does not include that period of time during which a Covered person is in a Hospital emergency room, an observation room, or a freestanding surgical facility or outpatient facility. Successive Confinements separated by 30 days or less will be considered as one Confinement.

Covered Person: Any or all of the following: You, You're Spouse or Your Children, who has been accepted by Us for coverage.

Deductible - means the amount of eligible medical expenses which must be satisfied for each covered loss before benefits are payable under this policy

Dependent – Your Child or Spouse as defined by the Certificate

Disability or Disabled – The inability, due to an injury or sickness to perform all of the substantial and material duties of your regular occupation.

For a Dependent Child or Spouse: "Disabled" means the inability to perform a majority of the normal activities of a person of like age in good health.

Effective Date – The date coverage is in effect is shown on the Schedule of Benefits. The effective date will start at 12:01 AM at the main place of business of the Policyholder.

Grace Period – The period of 31 days allowed for each dues payment after the first dues payment.

Group Master Policy or Policy: The complete contract of benefits, which includes the Policy as issued to the Policyholder, as well as any Certificates issued to members, including any Amendments, Endorsement, Riders, Applications or Enrollment Forms signed by the Policyholder and each covered person.

Policyholder – The entity named on the Cover Page of the Policy

Hospital – A licensed institution that has on its premises or in facilities available to the Hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly Licensed Physicians.

1. Laboratory, X-ray equipment and operating rooms where major surgical operations may be performed by licensed Physicians.
2. Permanent and full-time facilities for the care of overnight resident bed patients under the supervision of a licensed Physician.
3. 24-hour-a-day nursing service by graduate registered nurses; and
4. A patient's written history and medical records.

The term "Hospital" does not include any institution used by the Covered Person as:

1. A place for rehabilitation;
2. A place for rest, or for the aged;
3. A nursing or convalescent home;
4. A long term nursing unit or geriatrics ward; or
5. An extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

Immediate Family Member – You, Your Spouse, Child, mother, father, and brother, sister or other close family member of the Covered person.

Injury or Off-the-Job injury - An injury which is caused by an Accident, and does not occur while in the course of any legal or illegal occupation, activity or employment for pay, benefit or profit.

Covered Person– The employee or member covered for these benefits and named on the Cover page of this Certificate,

Intensive Care Unit – A specially designated area of a Hospital that provides the highest level of medical care restricted to those patients who are critically ill or critically injured. It must be separate and apart from the surgical recovery room and other rooms, wards, or beds normally used for patient confinement. It must also:

1. Be provided with constant and continuous nursing care by nurses assigned to it on a full-time basis; and
2. Be under the full-time direction and/or supervision of either a Physician or a standing committee of the Hospital's medical staff; and
3. Contain special life saving equipment.

Intensive Care Unit includes: Intensive cardiac and coronary care units, neonatal intensive care units, and burn intensive care units if such units meet the conditions in this definition. This does not include any lesser treatment units.

Loss Period - means that period of time, as stated on the Schedule of Benefits, from the date of an accident within which a covered person must seek initial treatment for an injury.

Maximum Benefit Amount - means the total benefit payable under an applicable benefit provision.

Medical Expense – means expenses incurred for Medically Necessary services and supplies. Not included are amounts in excess of Usual and Customary Charges.

Occurrence – means each separate Accident or Sickness for which a covered person incurs medical expenses.

Physician – A licensed practitioner of the healing arts who:

1. Performs only those services permitted by his or her license; and
2. Is not an immediate Family member.

Pre-Existing Condition – A Sickness or physical condition for which the Covered person:

1. Had treatment;
2. Incurred Expense;
3. Took medications; or
4. Received a Diagnosis or advice from a Physician.

During the 12 month period immediately before the Effective Date of the Covered Person's coverage.

The term "Pre-existing" will also include a condition that manifests itself in a way that would cause an ordinary prudent person to seek medical advice, diagnosis, care or treatment.

Schedule of Benefits or Schedule – The benefit schedule set forth in this Certificate.

Sickness – An illness or disease which first manifests itself while the Covered person's coverage is in force and is the direct cause of the loss.

Spouse – Your legally married Spouse named in the Application or Enrollment Form. If you are not legally married, "Spouse" may include your common law spouse if named in the Application or Enrollment Form and if legally recognized in the state in which you reside.

Testing Day – The day on which one or more diagnostic X-rays or laboratory tests are performed.

Usual and Customary Charges – means the following (1) a usual fee is defined as the charge made for a given service nu a Doctor to the majority of his patients; and (2) a customary fee is one which is charged by the majority of the Doctors within a community for the same services. All benefits are limited to the Usual and Customary charges.

Waiting Period – The period of time from your date of employment or membership that must expire before you are eligible to enroll for coverage, as specified in the Policyholder's Application.

We, Us, or Our – The company that underwrites this coverage.

You, Your, or Yours – The Member.

ELIGIBILITY AND EFFECTIVE DATE

Effective dates are shown on your membership cards. Coverage will start on such date at 12:01 AM at the main place of business of the Policyholder. Effective dates for all persons added to coverage after this Certificate is issued will be shown on the Schedule of Benefits issued at the time of the addition.

Employer or Member Eligibility – To be eligible for benefits you must:

1. Meet eligibility requirements as selected on the Policyholder's Application;
2. Satisfactorily answer all eligibility and other questions on the Application or Enrollment Form and must provide evidence of eligibility satisfactory to us, if we ask for it; and
3. Be actively at work or eligible to work if currently unemployed. Either as a business owner, independent contractor, works for a small business or a member of a workers union.

Employee or Member Effective Date – Your coverage will take effect on the Effective Date of the Policy if:

1. You completed an Application or Enrollment Form on or before the effective date; and
2. You are in Active Service or eligible to be in Active Service; and
3. Your first dues payment has paid and received by Us.

If you are not eligible for this coverage on the Policy effective date, Your coverage will take effect on the first day of the day which coincides with or next follows the date You first become eligible and are approved for coverage. Additionally, Your first dues payment must have been received by Us, and all provisions listed in the Employee or Member Eligibility provision above, must be met.

If you are disabled on what otherwise would be the effective date, Your coverage will be deferred until the first of the month following the date you cease to be disabled.

Dependent Eligibility – If Dependent coverage is available, A Dependent will be eligible for such coverage on the later of the following dates:

1. The day you become eligible for coverage; or
2. The day he/she first meets the definition of Dependent.

You may elect dependent coverage by:

1. Applying for Dependent coverage within 31 days of the date the dependent becomes eligible; and
2. Completing any required forms for payroll deduction or drafting of your account for payment

You must complete an Application for Enrollment of a Spouse or Child, and pay any required dues within 31 days of the date Your Spouse or Child meets these eligibility criteria. If such Application is not made within that 31 day period Your Spouse or Child will be considered a late enrollee and may be required to submit satisfactory proof of eligibility in order for coverage to become effective.

Any eligible Dependent who does not become a covered person on your effective date may be added to this Certificate subject to:

1. The Completion of an Application or Enrollment Form;
2. Satisfaction of any proof of eligibility requirements; and
3. Payment of any additional premium, if required.

If you and your spouse are both eligible as an employee or member, the Children may be covered as Dependents of either You or your Spouse but not both

Dependent Effective Date – The effective date of coverage for each eligible Dependent will be on the first day of the month that coincides with or next follows:

1. Our acceptance of the Application or Enrollment Form; and
2. Our receipt of the first dues payment.

However, if on such date Your coverage has not yet taken effect, the effective date for dependent coverage will be the same as your effective date.

If a Dependent is disabled on the date coverage (with respect to that particular Dependent) would otherwise be in effect, the coverage for that Dependent will be deferred until the first of the month following cessation of Disability for that Dependent.

Newborn Child Effective Date – A newborn Dependent Child will become covered for coverage automatically on the day he or she is born, so long as your coverage is in force on that date. Coverage includes premature babies, congenital defects and birth abnormalities. The Dependent newborn child's coverage will not continue past the 31 day period following the date of birth, unless:

1. You have notified Us by the end of the 31 day period of the addition of such newborn Child, and
2. You have paid any applicable additional dues.

DESCRIPTION OF BENEFITS

Subject to the provisions of this certificate, and any maximum benefit limitations stated on the schedule of benefits, we will pay a benefit for a covered loss that occurs while the covered person is covered under the policy, subject to extension of Benefits Provision. Please see the Schedule of Benefits for the benefit amount details for each benefit listed below.

Accidental Death Benefit

If bodily injury results in the loss of the Covered person's life within the Loss Period stated on the Schedule of Benefits, we will pay the Principal Sum shown on the Schedule of Benefits.

Medical Expense Benefit – Accident and Sickness (Out-Patient Only)

After the Deductible amount shown on the Schedule of Benefits has been satisfied, we will pay a percentage of the Usual and Customary Charges, as shown on the Schedule of Benefits, for covered medical expenses, up to the Maximum Benefit shown on the Schedule of Benefits. Benefits will be paid for the Benefit Period shown on the Schedule of Benefits. Benefits will be paid for covered medical expenses that are incurred while the Covered Person's coverage is in force. The Covered Person must be under a Physician's care, and the treatment must be Medically Necessary, for the Covered Sickness or Injury. Benefits will only be paid for expenses which are incurred during the Benefit Period shown on the Schedule of Benefits.

Hospital Confinement – Injury and Sickness

We will pay the Daily Benefit amount shown on the Schedule of Benefits for each day the Covered Person is a registered in-patient in a Hospital if:

a) It is the result of a accidental bodily injury, directly and with no other causes, or Sickness, while this coverage is in force; and
b) The Covered Person is under a Physician's care; and
c) The Hospital Charges at least a full day's room and board; and
d) The Hospital stay begins while the Covered person is covered.

Payment of the Daily Benefit will start on the first day of confinement and will continue for a period not to exceed the Maximum Benefit Period, as shown on the Schedule of Benefits, for each period of Hospital confinement. If Hospital confinement for the same injury or sickness is not continuous, benefits are subject to the "Recurrent Period" (as defined)

"Recurrent Period" means that two or more periods of Hospital confinement, due to the same Injury or Sickness, are treated as one period if separated by less than 180 days between confinements.

EXCLUSIONS AND LIMITATIONS

With respect to all the benefits provided under this Certificate, no benefits will be payable as the result of:

1. Suicide or any attempt thereof, while sane or insane;
2. Any Intentional self-inflicted Injury or Sickness;
3. Rest care or rehabilitative care and treatment (unless provided as a benefit on the Schedule of Benefits);
4. Participating in a riot, civil commotion, civil disobedience, or unlawful assembly;
5. Committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation;
6. Participation in:
    a. An organized contest of speed;
    b. Parachuting;
    c. Parasailing;
    d. Bungee Jumping; or
    e. Hang Gliding;
7. Air travel, except:
    a. As a fare-paying passenger on a commercial airline on a regularly scheduled route; or.
    b. As a passenger for transportation only and not as a pilot or crew member;
8. Any accident caused by the participation in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician or taken according to the Physician's instructions) or while intoxicated (intoxicated means that condition as defined by the law of the jurisdiction in which the Accident occurred);
9. Any procedure or treatment to change physical characteristics to those of the opposite sex and other treatment related to sex change;
10. The reversal of a tubal ligation or vasectomy;
11. Artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or Physician's services, unless required by law;
12. Any loss incurred while on active duty status in the armed forces (if You notify us of such active duty, we will refund any dues paid for any period for which no coverage is provided as result of this exception.);
13. Accident or Sickness arising out of and in the course of any occupation for compensation, wage or profit OR expenses which are payable under Occupational Disease Law or similar law, whether or not application for such benefits has been made;
14. Routine eye examinations or fitting of eye glasses;
15. Hearing aids or fitting of hearing aids;
16. Dental examinations or dental care other than expenses resulting from an Accident;
17. Care or treatment of an Accident or Sickness not specifically provided for in this plan;
18. With respect to the Off-the-Job Accidental Injury Benefit only, charges that the Covered Person is not legally required to pay, or charges which would not have been made if this coverage had not existed; or
19. Treatment of an Accident or Sickness made necessary by or arising from war, declare or undeclared, or any act of war;
20. Cosmetic Surgery, except cosmetic surgery which the covered person needs as a result of an Accident which happens while he is covered under this policy. The surgery must be performed within 90 days of the Accident causing the injury and while such person's coverage is in force;
21. Weight loss treatment;
22. Treatment of the feet (including but not limited to corns, calluses or bunions) for other than Accidental Injury
23. Correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratomy and all related services;
24. With respect to Accidental Death benefits, sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof; or bacterial or viral infection, regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of an accidental external bodily injury or accidental food poisoning.

Pre-Existing Conditions - We will not pay any benefits for a condition for which a Covered person received medical treatment, care or advice within 12 months before being covered under this Policy. This does not apply if:

a) The Covered person has been covered under this policy for 12 consecutive months; or

b) the condition is pregnancy; or

c) he is a child who is adopted or placed for adoption before attaining the age of 18 years and who, as of the last day of the 30 day period beginning on the date of the adoption or placement for adoption, is covered under Creditable Coverage.

Credit for Prior Coverage - A Covered person, whose coverage under prior Creditable Coverage ended no more than 63 days before the Covered Person's effective date under this policy, will have any applicable Pre-Existing Condition limitation reduced by the total number of days the Covered Person was covered by such coverage. If there was a break in Creditable Coverage of more than 63 days we will credit only the days of such coverage after the break.

Creditable Coverage means coverage under any of the following:

a) Any individual or group policy, contract or program, that is written or administered by a disability insurance company, health insurance company, health care service plan, fraternal benefits society, self-insured employee plan, or any other entity, and that provides or arranges medical, hospital and surgical coverage not designed to supplement other private or government plans. The term includes continuation coverage, conversion coverage, but does not include accident only, credit, disability income, Medicare supplement, long term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation or a similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;

b) The federal Medicare program pursuant to Title XVIII of the Social Security Act; The Medicaid program pursuant to Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; Chapter 55 of the Title 10, United States Code, the Civilian health and Medical Program of the Uniformed Services;

c) a medical program of the Indian Health Service or of a tribal organization; a state health risk benefits pool; a health program offered under chapter 89 of Title 5, United States Code, the Federal Employees Health Benefits Program, a public health plan as defined by federal regulations, or a health benefit program under section 5(e) of the Peace Corp Act.

DUES

All dues are payable on or before the date they are due. You must pay any required contribution to the Policyholder.

We have the right to change the dues rates on any dues due in accordance with the terms of the Policy. If the rates are changed after the first Policy anniversary We will give at least a 31-day advance written notice to the Policyholder.

Grace Period – There is a 31 day grace period after each dues due date after the first dues payment. If a subsequent dues payment is not paid on time, coverage will stay in force during the grace period. Coverage will end at the end of the grace period, if the dues are not paid by then. If this happens the dues for the grace period will still be owed to us.

TERMINATION OF COVERAGE

Your coverage will cease on the earliest of:

1. The last day of the payroll deduction period during which You can cease to be eligible for coverage;
2. The end of the last period for which a dues payment has been made to Us;
3. The date the policy terminates; or
4. The last day of the payroll deduction period during which You terminate employment.

The coverage on a Dependent will cease on the earliest of:

1. The date Your coverage terminates;
2. The end of the last period for which a dues payment has been made to Us;
3. The date of the Dependent no longer meets the definition of Dependent; or
4. The date the Policy is modified so as to exclude Dependent coverage.
5.

We will have the right to terminate the coverage of any Covered Person who submits a fraudulent claim under the Policy.

Extension of Benefits – Whenever termination of coverage under this section occurs due to the termination of Your employment or membership such termination will be without prejudice to:

1. Any Hospital Confinement which commenced while coverage was in force, with respect to Daily In-Hospital Indemnity Benefits; or
2. Any covered treatment or service for which benefits would be provided and which commenced while coverage was in force; provided, however, that the Covered Person is and continues to be Hospital Confine or Disabled.

Such Extension of Benefits will continue for up to the earlier of:

1. 30 days; or
2. The date on which the Covered Person is no longer disabled.

CLAIMS PROVISIONS

Claim Forms – Claims forms should be used for filing Proof of Loss. We will send such form to claimant within 15 days of receipt of notice of claim. If we fail to supply the proper claim forms within 15 days. You can give proof in writing, setting for the nature and extent of loss within the time stated in the Proof of Loss Provision.

Claims Procedure – Due Proof of Loss must be submitted to us at our administrative Office. You or a personal representative may obtain a claim form by calling Our toll-free telephone number listed on the Cover Page.

Notice of Claim – Written notice of claim must be given to Us at Our Administrative Officer, or to Our agent. Such notice should be made within 31 days after any loss covered by the Policy. If it is not reasonably possible to give notice within that time, the claim may not be denied or reduced due to delay.

Proof of Loss – Written proof of loss must be given to us or our authorized representative with 90 days after the loss begins. The Company will not deny or reduce any claim if it was not reasonably possible to give the proof of loss in the time period required. In any event, proof of loss must be given to us or our authorized representative within 1 year after it is due, unless the insured is legally incapable of doing so.

Payment of Benefits – Benefits may be assigned to the provider(s) of such benefits. If you show proof of payment to the provider all benefits payable under the Policy will be paid to You. Accrued benefits that are not paid at Your death will be paid to Your estate. We may pay up to $1,000.00 of such benefit to one of Your relatives at Our discretion. Such payment fully discharges Us to the extent of the payment.

Physical Examination and Autopsy - At our expense, we may: (1) have a person claiming benefits examined as often as reasonably necessary while the claim is pending; and (2) to make an autopsy in case of death where it is not forbidden by law.

Legal Action – No legal action may be brought to recover on this policy before 90 days after written proof of loss has been furnished as required by this policy. No such action may be brought after 2 years from the time written proof of loss is required to be furnished.

Coordination of Benefits: This provision will be used to determine a Covered Person's benefits under this policy. If the covered person is covered for medical benefits under this policy and is also covered for these benefits under other plans; and the benefits that would be paid by this policy without this section plus the benefits that would be paid by the other plans, without a section similar to this section would exceed allowed expenses as defined below.

Allowed expenses means Medical Expenses which are:

Medically necessary
Not in excess of Usual and Customary Charges
Incurred while the person for whom the claim is made is covered, or is entitled to benefits after coverage ends under this policy; and
At least partly covered under one of the plans covering such person.

When this policy does not pay its benefits first, allowed expenses will include medical expenses which are not paid because of the claimant's failure to comply with the cost containment requirements of the plan which pays its benefits first.

When a plan provides a benefit rather than a cash payment, the reasonable cash value of the service will be considered to be both an allowed expense and a benefit paid.

Effects Under this Plan – When this provision is used, the rules listed below will determine the amount of benefit each plan will pay. All benefits will be determined on a policy year basis.

These rules may require this plan to pay its benefits first. If so, this plan will pay its full benefits without taking into account other plan benefits. These rules may require one or more of the other plans to pay their benefits before this plan. If so, this plan will reduce its benefits so that in any policy year, the sum of all benefits paid to a person (by this and all other plans) equals the allowed expenses for that year. Benefits to be paid under other plans include benefits before a plan that has such a provision.

A plan or part of one that does not have a provision similar to this section will pay its benefits before a plan that does have a provision.

In all other cases, the plan that will pay its benefits first will be dependent upon the first applicable rule:

a) The benefits of the plan covers the Covered person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the covered person as a dependent.

b) Dependent child/Parents not divorced. The rules for the order of benefits for a dependent child when the parents are not divorced is as follows:

(1) The benefits of the plan of the parent whose birthday falls earlier in a year determined before those of the plan of the parent whose birthday falls later in the year.

(2) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

(3) If the other plan does not have the rule described in (1) and (2) above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the other of benefits. The rule based upon the gender of the parent will determine the order of benefits.

c) Dependent Child/Divorced parents. If two or more plans cover a covered person as a dependent child of divorced parents, benefits for the child are determined in this order:

(1) First, the plan of the parent with custody of the child;

(2) Then the plan of the spouse of the parent with custody of the child, and;

(3) Finally, the plan of the parent not having custody of the child.

(4) If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. The paragraph does not apply with respect to any claim determination period or policy year which any benefits are actually paid or provided before the entity has that actual knowledge.

(5) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of rules in (b) above.

d) Longer/Shorter length of coverage. If none of the above rules determine the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered the person for the shorter term.

(1) To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the covered person was eligible under the second within 24 hours after the first ended.

(2) The start of a new plan does not include: (i) a change in the amount or scope of a plans benefits; (ii) a change in the entity that pays, provides or administers the plan's benefits; or (iii) a change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan or an Association Plan).

(3) The covered person's length of time covered under a plan is measured from the covered person's first date of coverage under that plan. If that date is not readily available, the date the covered person first became a member of the group shall be used as the date from which to determine the length of time the covered person's coverage under the present plan has been in force.

If the benefits of this plan are reduced due to these rules, such reduction will be done in proportion. Any benefits paid by this plan on a reduced basis will be charged against the benefit limits of this plan.

For this provision to work, we must exchange information with other plans. To do so, we may have to give or get from any source all such information we think necessary. This will be done without the consent or notice to any person except as required by the applicable federal or state statue. Any person claiming benefits under this plan must give us the information it requires.

Facility of Payment
Another plan may pay a benefit what should be paid by us by the terms of the provision. If that happens, we may pay to such payer the amount required for it to satisfy the intent of this provision. This will be done at our discretion. Any amount so paid will be considered a benefit under this plan. We will not be liable for such payment after it is made.

GENERAL PROVISIONS

Changes to this Certificate – Only Our President, Vice-President, Secretary or an Assistant Secretary may make any changes to this Certificate and then only in writing. No agent or Policyholder has authority to change the Policy of this Certificate or to waive any of its provisions. Any changes are subject to the laws of the governing jurisdiction.

Entire Contract – The entire Contract consists of the Policy, the Certificate, any attached Amendments, Endorsements, or Riders, the Policyholder's Application, Your Applications and any Enrollment forms.

Grace period – A grace period of 31 days will be allowed for each dues payment after the first dues payment is paid. Coverage will stay in force during this period. The coverage under the Policy and/or Certificate will terminate at the end of the Grace Period if the dues have not been paid. You must still pay all unpaid dues. This includes the dues payment due for the Grace Period.

If coverage is canceled on a dues due date and the dues have been paid through that date, the Grace period will not apply. If coverage is canceled during the Grace Period, you will be liable for any unpaid dues including the pro rata dues for that part of the Grace Period which coverage was in force. Benefits may be reduced by the amount of any due, but unpaid dues.

Legal Action – No legal action may be brought to recover under the Policy and or Certificate:

1. Within 90 days after proof of Loss has been furnished as required; or
2. More than two years from the time written Proof of Loss is required to be furnished.

Misstatement of Age – If the covered person's age has been misstated, the covered persons true age will be used to adjust the dues or adjust the benefits paid.

No Dividends Payable – This Certificate does not participate in the profits or surplus earnings of Our Company.

Right to Contest – We will not use any statement, except fraudulent statements, to void or reduce benefits after this Certificate has been in force during your lifetime for two years from the effective date of coverage. Any such statement would have to be in a signed form. This also applies to all riders. Any increase in benefit amounts would be subject to a new two year contestable period for the increased amount only.

All statements made are considered representations and not warranties. No such statement will be used in any contest, unless a copy of such statement has been furnished to you.

When Notice is Given to Us – Any notice to You will be sent to your last known address.

AMENDATORY RIDER

This rider is made a part of the policy or certificate to which it is attached. It is subject to all the terms of the policy or certificate which are not in conflict with this rider.

The rider date shall be the same as the Policy date or Certificate dare if no date is shown. The same pre-existing conditions exclusions are in effect for the rider as they are for the certificate itself.

Maternity Benefit

If the policy covers Medical Benefits for Sickness, we will pay the Usual and Customary Charges incurred for a minimum of forty eight hours of inpatient care following a vaginal delivery and minimum of ninety six hours of inpatient care following delivery by caesarean section for a mother and her newborn in a Hospital or birthing center. Shorter stays are allowed if recommended by the attending health care provider in consultation with the mother and one postpartum visit is performed within 48 hours of discharge.

Charges for medical expenses incurred for a postpartum follow-up visit are also covered. Such visit must occur within 48 hours of discharge from the Hospital or birthing center and can be performed by a licensed health care provider whose scope of practice includes postpartum home care. Coverage includes:

a) Physical assessment of the covered mother and newborn child;
b) Parent education;
c) Training or assistance with breast or bottle feeding, and;
d) The performance of any appropriate clinical tests. At the covered mother's discretion the visit may occur at the health care provider's facility or hospital.

The benefit will be paid on the same basis as any other Sickness under the policy, subject to the same deductibles, coinsurances and maximums/

Breast Reconstruction Benefit

If the policy covers Medical Benefits for Sickness, we will pay the Usual and Customary charges incurred for reconstructive breast surgery resulting from a mastectomy.

Coverage is also provided for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with the diseased breast and for prostheses and physical complications at all stages of the mastectomy.

The benefit will be paid on the same basis as any other sickness under the policy, subject to the same Deductibles, coinsurance and maximums.

Lead Poisoning Screening Benefit

If the policy covers Medical Benefits for Sickness, we will pay the Usual and Customary Charges incurred for a baseline lead poisoning screening test for covered dependent children at or around 12 months of age and lead poisoning screening and diagnostic evaluations for covered dependent children under the age of 6 years who are at high risk for lead poisoning in accordance with guidelines and criteria set forth by the Division of Public Health.

This benefit will be paid on the same basis as any other sickness under the policy, subject to the same Deductibles, coinsurance and maximums.

Cancer Screening Tests Benefit

If the policy covers medical benefits for Sickness we will pay the Usual and Customary Charges incurred for cancer screening tests performed by a qualified facility or Doctor as follows:

One annual cervical and endometrial cancer screening known as a pap smear for a female covered person aged 18 and over.

a) Prostate cancer screening, known as a prostatic specific antigen (PSA) test, for a covered person age 50 or above
b) Periodic mammographic examinations, including the facility and radiologist fees, on the following schedule:
    a. A baseline mammogram for an asymptomatic female covered person at least age 35;

b. A mammogram every 1 to 2 years for an asymptomatic female covered person age 40 to 50 but no sooner than 2 years after her baseline mammogram, or as otherwise declared appropriate by her doctor;
c. A mammogram every year for an asymptomatic female covered person age 50 and older;
d. A mammogram prescribed by a Doctor for a female covered person based on such Doctor's evaluation of her physical conditions, symptoms or risk factors indicating a probability of breast cancer higher than the general population.

c) Colorectal cancer screening as follows:

a. For covered persons 50 years of age or older: screening with annual fecal occult blood tests (4 specimens), flexible sigmoidoscopy every 5 years, colonoscopy every 10 years, double contrast barium enema every 5 years, or any combination of the most reliable, medically recognized screening tests as may be determined by the Secretary of Health and Social Services;
b. For covered persons who are deemed at high risk for colon cancer because of family history of familial adenomatous polyposis, family history of hereditary nonpolyposis colon cancer, chronic inflammatory bowel disease, family history of breast, ovarian, endometrial, colon cancer or polyps, or a background, ethnicity or lifestyle such that the treating health care provider believes the covered person is at elevated risk:

Screening by colonoscopy, barium enema or any combination of the most reliable, medically recognized screening tests available as may be determined nu the Secretary of Health and Social Services shall be covered at a frequency determined by the Doctor.

This benefit will be paid on the same basis as any other Sickness under this policy subject to the same Deductibles, coinsurance and maximums.

Ovarian Cancer Monitoring Benefit
If the policy covers Medical Benefits for Sickness, we will pay the Usual and Customary Charges incurred for CA-125 monitoring of ovarian cancer. Coverage is not provided for routine screening.

The benefit will be paid on the same basis as any other Sickness under this policy subject to the same Deductibles, coinsurance and maximums.

Serious Mental Illness
If the policy covers Medical Benefits for Sickness, we will pay the Usual and Customary Charges incurred for diagnosis and medically necessary treatment of a Serious Mental Illness on an inpatient or outpatient basis as long as services are rendered by a mental health professional licensed or certified by the State Board of Licensing or in a mental health facility licensed by the State.

Serious mental illness means any of the following biologically based mental illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

a. Schizophrenia;
b. Bipolar Disorders;
c. Obsessive-compulsive disorders;
d. Major depressive disorders;
e. Panic disorders;
f. Eating disorders including anorexia nervosa and bulimia nervosa;
g. Schizoid-affective disorders; and
h. Delusional disorders.

Treatment of alcoholism or other drug dependencies, including through the diagnosis or treatment of one of more Serious Mental Illness, is not covered.

This benefit will be paid on the same basis as any other Sickness under this policy, subject to the same Deductibles, coinsurance and maximums.

Childhood Immunizations Benefit

If the policy covers medical benefits for sickness, we will pay the Usual and Customary Charges incurred for each covered dependent child from birth through the date the child is 18 years of age for immunizations against: (a) Diphtheria; (b) Hepatitis B; (c) Measles; (d) Mumps; (e) Pertussis; (f) Polio; (g) Rubella; (h) Tetanus; (i) Varicella; (j) Haemphilus influenza B; and (k) Hepatitis A.

This benefit will be paid on the same basis as any other Sickness under this policy, subject to the same Deductibles, coinsurance and maximums.

Prescriptions Contraceptive Benefit

If the policy covers medical benefits for sickness, we will pay the Usual and Customary Charges incurred for prescription contraceptive drugs and devices approved by the FDA and for outpatient contraceptive services including consultations, examinations, procedures, insertion and removal, and medical services related to the use of contraceptive methods to prevent unplanned pregnancies.

This benefit will be paid on the same basis as any other Sickness under this policy, subject to the same Deductibles, coinsurance and maximums.

Diabetes Benefit

If the policy covers medical benefits for sickness, we will pay the Usual and Customary charges incurred for the following equipment and supplies for the treatment of diabetes if recommended by a Doctor; insulin pumps, blood glucose meters and strips, urine testing strips, insulin, syringes, and pharmacological agents for controlling blood sugar.

The benefit will be paid on the same basis as any other Sickness under this policy, subject to the same Deductibles, coinsurance and maximums.

Off Label drug benefit

If the policy covers medical benefits for sickness, we will pay the Usual and Customary Charges incurred for any drug, including medically necessary services associated with administration of the drug, to treat a covered person for a covered chronic, disabling, or life threatening Sickness if the drug:

a. Has been approved by the FDA for at least one indication; and
b. Is recognized for treatment of the indication for which the drug is prescribed in prescription drug reference compendium approved by the Insurance Commissioner for this purpose or in substantially accepted peer reviewed medical literature.

Coverage is not provided for experimental drugs not otherwise approved for any indication by the FDA nor for any disease or condition that is excluded from coverage under this policy.

This benefit will be paid on the same basis as any other Sickness under this policy, subject to the same Deductibles, coinsurance and maximums.

Nonduplication of Benefits

No benefits are payable under this rider for that portion of Medical Expenses for which benefits are payable under the policy or certificate or another rider attached to it. If benefits are payable under more than one provision, then benefits will be provided only under the provision providing the greater benefit.

Nothing contained in this rider will alter, waive or extend the provisions, conditions or limitations of the policy, except as expressly stated above.

IMPORTANT INFORMATION TO POLICYHOLDERS

In the event you need to contact anyone about this policy for any reason please contact your agent. If you have additional questions you may contact us at the following address and telephone number:

American Trade Association, Inc.

Customer Service Center
4676 Highway 41 North
Springfield, TN. 37172

(800) 591-6764

All of the above information relates to the Limited Benefit Hospital Indemnity Policy issued to your Policyholder

The Association provides additional benefits which are described and outlined in the material you will receive. Please be aware that not all the Association benefits are underwritten and many are discount programs offered to you as a member of the Association.

ACCIDENT MEDICAL
IN-HOSPITAL ACCIDENT ONLY
ACCIDENTAL DEATH AND DISMEMBERMENT

SCOPE OF COVERAGE

We will provide the benefits described in this certificate to all Covered Persons who suffer a covered loss which is within the scope of the DESCRIPTION OF BENEFITS PROVISIONS and results, directly and independently of all other causes, from bodily injury which is suffered in an Accident, and occurs while the person is a Covered Person under this certificate and is within the scope of the risks set forth in the DESCRIPTION OF HAZARDS provisions.

COVERED PERSONS include all members and their lawful spouses under age 70.

Accident means a sudden, unforeseeable external event which causes injury to one or more Covered Persons and occurs while coverage is in effect for the Covered Person.

THIS IS A LIMITED ACCIDENT ONLY BENEFIT. IT IS ACCIDENT ONLY CERTIFICATE AND DOES NOT COVER LOSS OR EXPENSE RESULTING FROM SICKNESS, DISEASE, OR BODILY INFIRMITY. In order to receive benefits, a COVERED person must sustain an injury while the CERTIFICATE is in force and such injury directly or independently causes a loss covered by the plan.

Benefits are payable for Eligible Expenses for non-work related injuries on the following basis:

DESCRIPTION OF BENEFITS

BENEFIT AMOUNT: $25,000 DEDUCTIBLE: $1,000 PER INJURY

If, as a result of injury, an insured incurs covered expenses starting within 90 days from the date of the accident causing the injury, we will pay, less the deductible as shown above and not to exceed the maximum benefit amount shown therein, all covered expenses incurred within one year from such date.

Covered expenses mean the usual, reasonable and customary charges for local professional ambulance service to or from a hospital and/or surgical center as well as the following usual, reasonable and customary charges for treatment, services and supplies provided or prescribed by a Doctor:

(1) Hospital Room & Board, or Surgical Center care and treatment; (2) Outpatient Hospital Emergency room; (3) Surgical Benefits; (4) Doctor's Visits In-Hospital; (5) Doctor Visits Out-Patient; (6) X-ray and Laboratory; (7) Nursing care; (8) Physiotherapy; (9) Ambulance (10) Medical Equipment Rental Charges; (11) Medical Services and Supplies (Blood, Blood transfusions, Oxygen); (12) Prescription Drugs; (13) Dental Treatment as a result of Injury to natural teeth

ACCIDENTAL DEATH & DISMEMBERMENT

Principal Sum: $50,000

If within one year from the date of an Accident covered under this certificate, Injury from such accident results in Loss listed below, we will pay the percentage of the Principal Sum set opposite the loss in the table. The amount will not exceed the Principal Sum which applies to the Covered Person.

ACCIDENT DEATH, DISMEMBERMENT, OR LOSS OF SIGHT

Loss	Percentage of Principal Sum
Loss of Life	100%
Loss of Both hands	100%
Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of One Hand	50%
Loss of One Foot	50%
Loss of Entire Sight of One Eye	50%
Loss of Thumb and Index Finger of the Same hand	25%

DISCRIPTION OF HAZARDS

24 Hour Coverage. We will pay the benefits described in this Certificate for any Accident which happens to a covered person while he is covered by this certificate. This includes travel or flight in an Aircraft with some restrictions. SEE EXCLUSIONS

GENERAL POLICY PROVISIONS

WORKERS' COMPENSATION INSURANCE: This Certificate is not in lieu of, and does not affect, any requirement for coverage under any Workers' Compensation Insurance.

EXCLUSIONS

Benefits will not be paid for a Covered person's loss which:

(1) is caused by or results from the Covered Person's own:

(a) Intentionally self-inflicted Injury, suicide or any attempt. (In Missouri this applies only while sane);
(b) Voluntary self administration of any drugs or chemical substance not prescribed by, and taken according to the directions of, a doctor (Accidental ingestion of a poisonous substance is not excluded);
(c) Commission or attempt to commit a felony;
(d) Participation in a riot or insurrection;
(e) Driving under the influence of a controlled substance unless administered on the advice of a doctor; or
(f) Driving while intoxicated. "Intoxicated" will have the meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs;

(2) is caused by or results from:

(a) Declared or undeclared war or act of war;
(b) An Accident which occurs while the Covered person is on active duty service in any armed forces. (Reserve or National Guard active duty for training is not excluded unless it extends beyond 31 days);
(c) Aviation, except as specifically provided in this Policy;
(d) Sickness, disease, bodily or mental infirmity or medical or surgical treatment

Bacterial or viral infection, regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of an accidental External bodily injury or accidental food poisoning.

(e) Nuclear reaction or the release of nuclear energy. However, this exclusion will not apply if the loss is sustained within 180 days of the initial incident and;

(i) The loss was caused by fire, heat, explosion or other physical trauma which was the result of the release of nuclear energy; and

(ii) The Covered Person was within a 25 mile radius of the site of the release either:
  (1) At the time of the release; or
  (2) Within 24 hours of the start of the release.

CLAIMS PROVISIONS

Written notice of claim must be given within 30 days after a covered loss occurs or as soon as reasonably possible. We will send forms to authorized members who ask for them.

Notice must be sent to the address below or call 1-800-591-6764

ATA ADMINISTRATOR
4676 HIGHWAY 41 NORTH
SPRINGFIELD, TN. 37172

PlanRx Preferred Prescription Program

You and your family can enjoy a prescription program that will save you money on virtually every prescription medication you may need. Our program offers you the following benefits:

- Retail/Mail Order Generic: $10 Maximum Member Payment per 30 day supply*
- Mail-Order Brands: $50 Maximum Payment per 30 day supply**
- Preferred Pricing on brand and generic medications not included under the Maximum Payment
- Pharmacy advisory services are required. This service is designed to maximize your savings

* Generic $10 Maximum Payment available through retail or mail order
** Preferred $50 Maximum Payment available through mail-order only

Retail/Mail Order Generic

- $10 or less for a 30-day supply for most Generics
- Very liberal formulary. See exceptions below
- Obtain up to a 90-day supply at the pharmacy – if prescribed
- Most over-the-counter (OTC) medications covered when substituted for a prescription
- All major chains and most independent pharmacies are in the network
- Very liberal maximum benefit based on 80% savings off current average retail pricing

Mail-Order: Preferred Pricing (Brand or Equivalent)

- $50 or less for a 30-day supply for medications on the formulary
- Available through mail-order only
- 90-day supply typically ordered
- Preferred Pricing offered for medications not included in formulary
- Pharmacy advisory services are required. This service is designed to maximize your savings

Limitations for Eligible "Retail" Generic Medications

The PlanRx "retail" generic Maximum Payment does not include generic medications not listed on the Covered Generic Formulary, diabetic supplies, fertility agents, sexual dysfunction medications, Injectibles, anorexiants, smoking deterrent medications, hair replacement products, cosmetic alteration drugs, Retin-A and ADHD medications for individuals over the age of 18, insulin syringes and accessories. Prescriptions are filled or refilled for up to a three (3) month's supply with a limit of 100 units per 30 days. A $10.00 maximum payment is applied for each 30-day supply.

After the member's Maximum Payment is applied, PlanRx will pay up to a maximum of $50.00 for a one month supply of a covered generic medication. In addition, PlanRx will pay a maximum of $1,200 per calendar year for each individual ($300 maximum each quarter) and a maximum of $2,400 per calendar year for a family ($600 maximum each quarter) for covered generic medications at your local network pharmacy.

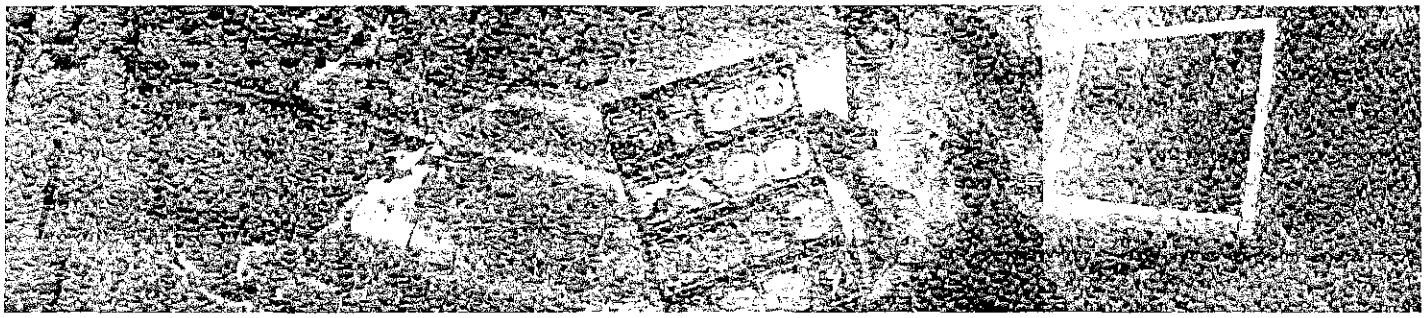
Mail-Order Medications

Preferred pricing medications are available through mail order only and generally are for a 90-day supply.

The medications included under the Maximum Payment are subject to change. It is our intent to include as many medications as possible. Any medication can be checked for preferred pricing. Mail-Order medication does not include some controlled substances and is limited to the number of units prescribed per 90-day period.

DIATRI™

CT Scan • MRI • P.E.T. Scan



w you have the power to plug into significant savings

MRI, CT Scans and P.E.T. Scans

Tri will:

- Schedule your procedure in a facility that is convenient for you.
- Help you to prepare for your procedure by answering any questions you may have and advising you of any restrictions that may be needed.
- Give you directions to the facility.
- Notify your physician of the date and time of your test.
- Place a reminder call to you the night before your test and make sure you are set to go.
- Work with your physician to be sure they have your results in a timely manner.

I will experience substantial savings on ir radiology needs.

make sure the facilities in our network highly credentialed and produce top ality tests.

How Does it Work?

Plan members will experience up to 70% savings on MRIs, P.E.T. and CT Scans in our nationwide network of highly credentialed radiology facilities.

Cost Without DiaTri

Diagnostic Facility Bills	$2000
PPO 15%	$1700

If applicable, member pays some or all of $200 deductible. Remaining amount: member pays either 10% or 20%.
Member Payment Range: $170-$500

DiaTri Cost - Example ONLY

Diagnostic Facility Bills	$2000
DiaTri Cost	**$ 800**

If applicable, member pays some or all of $200 deductible.

Remaining amount: member pays either 10% or 20%
Member Payment Range: $80-320

Quality Care:
DiaTri also works with your physician to ensure they know the time and place of your test and makes sure your physician receives your results in a timely manner.

To Schedule Call:
800-591-6764
Visit DiaTri at: www.diatri.net

Fan Club Members save 10%

on Universal Orlando® Resort tickets and vacation packages

AND

Enjoy special vacation offers year-round!

Take A Vacation from the Ordinary® at Universal Orlando Resort, the only place where you'll find the world's two most amazing theme parks—Universal Studios®, where you can jump into the action of your favorite movies, and Universal's Islands of Adventure®, where you'll feel the adrenaline rush of the most innovative rides and attractions ever created.

Plus you can enjoy the non-stop entertainment at Universal CityWalk®, and stay at magnificently themed on-site hotels including the luxurious Portofino Bay Hotel, A Loews Hotel, the exciting Hard Rock Hotel®, and the exotic Royal Pacific Resort, A Lowes Hotel.

Build your own Universal vacation and save 10%. Select from a variety of hotel accommodations, theme park tickets, dining options, Orlando area attraction passes and more!

Savings on tickets and vacation packages can be obtained by visiting:
www.universalfanclub.com/orlando/memberbenefits/nationalfcmembers.htm

AmeriCare Health

Because Health Matters, Because Saving Matters

2010 Open Enrollment Information

Standard, Premier, Elite & National Choice Plans

All levels of benefit are provided via your Association Membership. By becoming a member of our association, you become eligible for medical coverage including Limited Medical Plans, Per Occurrence Plans and Major Medical Plans. Please see the description of benefits to see which level of benefit is best suited for your needs.

HIPAA

COMPLIANT

AmeriCare Health
Because Health Matters, Because Saving Matters

Fax this page along with the enrollment form back to:

(904) 395-9043

Dear Sir or Madam,

Congratulations on your new membership in our association and association medical benefits through ATA and AmeriCare Health. We at AmeriCare Health work hard to reach out to new and existing members and fulfill the overwhelming need for affordable association medical benefits through respectable carriers and associations. You recently enrolled during an open member registration period and through the association we were able to give you the best possible rate. Included in this letter we have provided a certificate, enrollment form, and fax number so that you can help another family member or friend in need. In most cases we are able to process one approved referral under the same rates as our open registration members received.

If you provide your friend or family member with the coupon and promotion code on the bottom of this page, and have them fax it back along with the enrollment form to (904) 395-9043, we will then issue an association membership along with their health benefits to the new member at the same rate structure you locked in. Please keep in mind, AmeriCare Health is only able to process the referral-based enrollments for the **next 30 days**.

Thank you for choosing AmeriCare Health along with ATA to serve your health care needs.

Sincerely,

Ben Logan
AmeriCare Health
In association with ATA and SDS

NEW MEMBER REFERRAL
Promotion Code: 090529ATA1

Referred By:

New Member Name:

Desired Effective Date:

Daytime Phone Number:

PLEASE FAX THIS PAGE ALONG WITH THE COMPLETED ENROLLMENT FORM TO:

(904) 395-9043

AmeriCare Health

Because Health Matters, Because Saving Matters

Enrollment Form - 11210AC

COMPANY INFORMATION

Company Name	Company Phone Number

PRIMARY MEMBER INFORMATION

First Name, Middle Initial, Last Name		Date of Birth	☐ Male ☐ Female
Street Address		Social Security # (Optional)	☐ Single ☐ Married
City, State, Zip Code		Height	Weight
Home Phone	Work Phone	Email Address	

ADDITIONAL FAMILY MEMBERS

Relationship	First Name	MI	Last Name	Date of Birth	Social Sec #	Gender
Spouse						☐ Male ☐ Female
Child 1						☐ Male ☐ Female
Child 2						☐ Male ☐ Female
Child 3						☐ Male ☐ Female
Child 4						☐ Male ☐ Female
Child 5						☐ Male ☐ Female

PLAN TYPE- Price Includes Association Membership On All Plan Types

						Total Monthly
☐ Basic (Association Only)	☐ Indiv	$55.79	RX N/A	☐ Dental+ (Incl.)	☐ CI Upgrade ($_____)	$
	☐ Couple	$57.20	RX N/A	☐ Dental+ (Incl.)	☐ CI Upgrade ($_____)	$
	☐ Family	$64.99	RX N/A	☐ Dental+ (Incl.)	☐ CI Upgrade ($_____)	$
☐ Standard (Limited Medical)	☐ Indiv	$209	☐ RX ($15)	☐ Dental+ ($15)	☐ CI Upgrade ($_____)	$
	☐ Couple	$299	☐ RX ($25)	☐ Dental+ ($25)	☐ CI Upgrade ($_____)	$
	☐ Family	$379	☐ RX ($35)	☐ Dental+ ($35)	☐ CI Upgrade ($_____)	$
☐ Premier 80/20 (Per Occurrence)	☐ Indiv	$305	☐ RX ($15)	☐ Dental+ ($15)	☐ CI Upgrade ($_____)	$
	☐ Couple	$424	☐ RX ($25)	☐ Dental+ ($25)	☐ CI Upgrade ($_____)	$
	☐ Family	$519	☐ RX ($35)	☐ Dental+ ($35)	☐ CI Upgrade ($_____)	$
☐ Elite 90/10 (Per Occurrence)	☐ Indiv	$354	☐ RX ($15)	☐ Dental+ ($15)	☐ CI Upgrade ($_____)	$
	☐ Couple	$469	☐ RX ($25)	☐ Dental+ ($25)	☐ CI Upgrade ($_____)	$
	☐ Family	$589	☐ RX ($35)	☐ Dental+ ($35)	☐ CI Upgrade ($_____)	$

☐ National Choice (Major Medical)	☐ Individual	$399/Month	RX Included – See Summary	$
	☐ Couple	$699/Month	RX Included – See Summary	$
	☐ Family	$899/Month	RX Included – See Summary	$

One Time Enrollment Fee: $

Total Inital: $

Representative Name:

Form Continues On Next Page

HEALTH QUESTIONS

1) Do you currently have insurance?	☐ No – List Previous Company: ☐ Yes – List Current Company:
2) Do you currently smoke?	☐ No ☐ Yes
3) Do you have any scheduled surgeries?	☐ No ☐ Yes – Please Explain:
4) Have you or any of your immediate family members been diagnosed with a terminal illness?	☐ No ☐ Yes – Please Explain:

ADDITIONAL NOTES/EXPLANATIONS

PLEASE LIST PRE-EXISTING CONDITIONS/PRESCRIPTIONS

By Signing Below You Agree To The Following:

I have read and confirm that the above information is true and accurate. Upon approval and by providing my payment information, I hereby authorize my account to be debited in the amount indicated above plus any selected upgrades (prescription, critical illness, etc) on a monthly basis plus a one-time enrollment fee of $75.00 for the Basic/National Choice Plans or $125.00 for the Standard, Premier, or Elite Plans for the first month only. I understand that the enrollment fee is non-refundable (except in those states where jurisdiction mandates otherwise).

Signed: _____ **Date:** _____

THIS SPACE INTENTIONALLY LEFT BLANK

AmeriCare Health
Because Health Matters, Because Saving Matters

ATTENTION:
All ATA Members without CRITICAL ILLNESS Coverage

Many of our members already enjoy the peace of mind that comes with $25,000 of additional Critical Illness coverage. For those of you who don't currently have this benefit rider on your plans, you may be pleasantly surprised at how affordable it actually is. As long as you don't have an outstanding Critical Illness claim such as cancer, heart attack, or major organ failure, then you can easily qualify for this inexpensive and valuable benefit. It is important to protect yourself and your family today.

Please see the current rates outlined below and call us with any questions about upgrading your plan today.

Call us at:

(877) 595-4320

Monday – Friday
10am to 6pm EST

	Non Tobacco Ages 18-49	Non Tobacco Ages 50-64	Tobacco Ages 18-49	Tobacco Ages 50-64
Individual	$24	$39	$34	$72
Couple	$34	$47	$44	$87
Family	$42	$72	$59	$132

Remember, this benefit is paid at 100% to the benefit maximum for the following:

- Life Threatening Cancer
- Heart Attack
- Stroke
- Major Organ Transplant
- Coronary Artery Bypass Surgery*

*This procedure is one of the most common and costly procedures in the United States currently. The average cost of a Coronary Artery Bypass Surgery as of 2008 is between $15,000 and $20,000.

American Trade Association

Welcome To the American Trade Association

Thank you for choosing the ATA as your Association. We are pleased to offer you as a member of the Association, our health benefits. We know you have many choices when looking for the right type of benefits and services for you and your family, and we appreciate the trust that you have placed in us.

Association Benefits

This welcome kit is designed to acquaint you with the services and benefits offered to you as a member of the American Trade Association. As a member, you are eligible to take advantage of any of the ancillary benefits offered through your Association.

Keep in mind that the Association offers you several ways to understand your benefits and how they work for you and your family. First, included in this Welcome Kit you will find information regarding the health benefits plan that you have chosen. If you have any questions about the benefits, or how to make them best work for you, please feel free to contact our customer service center and speak to one of our knowledgeable staff members. Our Customer Service Staff are all trained professionals and are available from 8:00 AM central time until 5:00 Central time Monday through Thursday and 8:00 until 3:00 PM on Fridays. Emergency admissions are always approved and handled for verification purposes on the following work day.

1-800-591-6764
ATA Customer Service

Again, please know we appreciate your confidence in the ATA and look forward to a long and mutually beneficial relationship. Our goal is not just to meet your expectations, but to exceed them. Because your *approval* is on the line.

ATA
HEALTH PLANS

FREQUENTLY ASKED QUESTIONS

1. Is the coverage guarantee issued? - You must be an eligible member of the Association to have the plan guaranteed issue for your group or business. To be eligible for Association membership you must be eligible to work (Not receiving disability benefits) at the time the policy is issued and you must be an Employer, Employee, Independent Contractor or self-employed and under the age of 65.

2. Are there pre-existing clauses or wait times for benefits? - This varies by plan. With the limited benefit mini-medical plans as long as you are an eligible member of the Association the plan is issued with no pre-existing exclusionary periods. The only exception is there is a thirty day waiting period for the Critical Illness benefit offered as part of the Premier 1000 plan. All other benefits are available immediately after the effective date of coverage. The Per-Occurrence plans are guarantee issue as long as you are an eligible member of the Association but carry a 12 month pre-existing condition limitation unless you have current creditable coverage and then depending on the time you have been covered the pre-existing can be waived. Check the Plan benefit information page for the exact terms and conditions.

3. Who is eligible for the plan? You must be at work on the day the plan becomes effective. You must either be an independent contractor, a business owner or work for a business as a full or part-time employee or contractor. You must be a member of the American Trade Association. You must not be disabled or unable to work due to health conditions at the time the plan goes into effect.

4. Does the plan cover me on the job? - You are covered for any sickness, illness or accident that is NOT job related. No on the job injury or sickness is covered under the benefits of this plan.

5. Do I have to go to a particular doctor or provider? No, you are free to go to any doctor or provider of your choice. To locate a provider, simply click on our site, **www.myatabenefits.com**, and follow the instructions to locate a provider in your area. You are not required to use network providers or hospitals but if you do use providers and hospitals that are members of this network any discounts for services will be passed on to you which will allow the indemnity benefit paid by the plan to go further in paying your medical expenses.

6. When is the effective date? Effective dates are either the 1st of the month or the 15th of the month. If we receive your application and first month's dues or your Company sends in an electronic enrollment form and dues prior to the 25th of the month your effective date will be the 1st of the next month. If received after the 25th and before the 10th of the next month your effective date could be the 15th of the month if desired. Any exceptions must be approved by Home Office prior to receipt of the applications.

ATA CUSTOMER SERVICE
1-800-591-6764

Administrative Office
American Trade Association, Inc.
4676 Highway 41 North
Springfield, TN. 37172
1-800-591-6764

Dear Member:

Thank you for choosing to become of a member of the American Trade Association and deciding to use our medical benefit product. The best way we know to say thank you is to provide you with world class customer service and support. That is something we will strive to do each and every day through our relationship with SDS, LLC., our third party administrator.

The details in this letter and the documents included in this packet are very important pieces of information. We recommend you put them in a safe place so that you can refer to them whenever necessary. Included in this packet is everything you will need to get the most out of your benefit program. You have made a smart purchase and our goal is to help you use it wisely.

Included in this packet are the following items and information:

- Your medical Indemnity Identifications Cards
- Notice of Privacy Policy
- Your Certificate of Medical Benefits
- As well as important information regarding the Association and its benefits included in your plan choice. Additionally you will receive a second set of cards and material detailing your dental, vision and other discount programs from People's Express shortly. Be on the lookout for that document as well as it is part of your Association benefit package.

Your Certificate of medical benefits includes the details of the level of benefit you have purchased. Please review it and if you have any questions now or in the future please contact customer service at the above number directly.

Use your Medical Indemnity Plan ID cards whenever you incur a claim. The information on it will help you and your provider understands the general coverages and will assist in filing a claim.

We will send you a copy of the explanation of benefits we send to your provider when we process one of your claims. It will help you understand how your benefits were paid and if there is a balance due the provider. This balance will be your responsibility to pay.

Information and records submitted for this coverage and any information received by SDS, LLC from your providers will be kept in complete confidence and privacy in compliance with all HIPAA Regulations.

If you ever have a question regarding your coverage or want to check on the status of a claim you have submitted, call ATA at 1-800-591-6764. You will be connected with a member of our Customer Care Team who will be able to answer your questions.

We hope you find this information useful and we appreciate your business. We promise to do everything possible to demonstrate that. If you have any questions, please give us a call and let us help.

Thank you,

You're ATA Customer Care Team

NOTICE OF PRIVACY POLICY

Information Only – No Response Necessary

Protecting your privacy is important to us. We want you to understand what information we collect and how we use it. We collect and use "nonpublic personal information" in order to provide our customers with a broad range of financial products and services as effectively as possible. We treat nonpublic information in accordance with our Privacy Policy.

What Information We Collect and From Whom we collect it

We may collect nonpublic information about you from the following sources:

- Information we receive from you on applications or other forms;
- Information about your transactions with us, our affiliates, or others; and
- Information we receive from nonaffiliated third parties, including consumer reporting agencies.

"Nonpublic information personal information" is nonpublic information about you that we obtain in connection with providing a financial product or service to you.

What Information we Disclose and to whom we disclose it

We do not disclose any nonpublic information about you to either our "affiliates" or non-affiliates without your express consent, except as permitted by law. We may disclose the nonpublic personal information we collect, as described above, to persons or companies that perform services on our behalf and to other financial institutions with which we have joint marketing agreements.

Our "affiliates" are companies which we share common ownership and which offer life and health benefits and other benefit products.

You're Right to Verify Accuracy of Information we collect

Keeping your information accurate and up to date is very important to us. You may access and correct nonpublic personal information about you that we collect except for information relating to claims or criminal or civil proceedings.

Our Security Procedures

We restrict access to your nonpublic personal information and only allow disclosures to persons and companies as permitted by law to assist in providing products and services to you. We maintain physical, electronic, and procedural safeguards to protect your nonpublic information. Should your relationship with us end, we will maintain and only disclose nonpublic information that we have about you in accordance with this Privacy Policy.

This Certificate explains the Limited Group Hospital Indemnity Benefits. Please read it closely to be familiar with your coverage.

Terms important in understanding the Certificate are defined in the Definitions section or in separate Certificate Provisions and are capitalized in this Certificate.

Important Notice – Benefits are payable as described in this Certificate for accidents or sickness that are incurred while the Covered person is covered under the Group Master Policy ("Policy")

The Policy under which this Certificate is issued may at any time be amended or canceled, as stated in its provisions. Such an action may be taken without the consent of or notice to any Covered Person. Dues are subject to periodic changes.

The benefits included under this Policy do not take the place of nor does it affect any requirements for coverage by Workers' Compensation or a similar type of insurance.

The benefits for Dependents described in this Certificate will be applicable to each of your Dependents only if you are a covered member and you have applied for coverage for each of your dependents. Such applications must be approved by Us, and the required dues paid for each dependent.

Policyholder:	American Trade Association, Inc.
Governing Jurisdiction:	Indiana
Policy Number:	ATA51111

Signed for the Company at Our Home Office to take effect on the Certificate Effective Date.

CERTIFICATE FOR LIMITED GROUP HOSPITAL INDEMNITY BENEFITS

LIMITED BENEFIT – READ YOUR CERTICATE CAREFULLY
NONPARTICIPATING – NO ANNUAL DIVIDENDS

Administrative Office:
ATA Administrators
4676 Highway 41 North
Springfield, TN 37172
Customer Service: 1-800-591-6764
Facsimile: 1-615-382-9594

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

BENEFIT COVERAGE

	PER COVERED PERSON
DAILY IN-HOSPITAL INDEMNITY AMOUNT	
BENEFIT AMOUNT PER DAY:	$500
MAXIMUM OF 30 DAYS PER CONFINEMENT	
DAILY INDEMINITY BENEFIT FOR CONFINEMENT IN AN INTENSIVE CARE OR CRITICAL CARE IN-PATIENT ROOM	
BENEFIT AMOUNT PER DAY:	$500
MAXIMUM OF 30 DAYS PER YEAR PER MEMBER	
IN-HOSPITAL & IN-PATIENT ADDITIONAL HOSPITAL INDEMNITY BENEFIT	
PER ADMISSION PER MEMBER:	$500
MAXIMUM VISITS PER YEAR PER MEMBER:	2
SURGICAL AND ANESTHESIA INDEMINTY BENEFIT	
BENEFIT FOR SURGERY PER SURGICAL VISIT AS LISTED IN THE TABLE OF SURGICAL INDEMNITY BENEFIT SCHEDULE:	$1,000 SCHEDULE
BENEFIT FOR ANESTHESIA PER SURGICAL VISIT	EQUAL TO 20% OF SURGICAL BENEFIT AMOUNT
OUTPATIENT PHYSICIAN OFFICE VISIT INDEMNITY BENEFIT - $25 CO-PAY	
BENEFIT AMOUNT PER OFFICE VISIT:	$50
MAXIMUM NUMBER OF OFFICE VISITS PER YEAR PER MEMBER:	6
OUTPATIENT INJECTIONS BENEFIT – MUST BE PERFORMED IN PHYSICIANS OFFICE - $25 CO-PAY PER VISIT	
BENEFIT AMOUNT PER VISIT	UP TO $100
MAXIMUM NUMBER OF VISITS PER YEAR PER MEMBER	6
OFF-THE-JOB ACCIDENT INJURY BENEFIT	
MAXIMUM BENEFIT:	$500
MAXIMUM NUMBER PER YEAR PER MEMBER:	5
OUTPATIENT DIAGNOSTIC X-RAY & LAB INDEMNITY BENEFIT	
BENEFIT AMOUNT PER VISIT PER MEMBER:	$50
CALENDAR YEAR MAXIMUM VISITS PER MEMBER:	4

EMERGENCY ROOM SICKNESS BENEFIT INDEMNITY BENEFIT	
BENEFIT AMOUNT PAID OER ER VISIT FOR SICKNESS OR ILLNESS:	$50
MAXIMUM NUMBER OF VISITS PER YEAR:	2
WELLNESS INDEMNITY BENEFIT	
BENEFIT AMOUNT PER VISIT PER MEMBER:	$50
MAXIMUM CALENDAR YEAR VISITS PER MEMBER:	1
WELL CHILD VISITS – 4 VISITS PER YEAR PER CHILD FROM 0 MONTHS TO 12 MONTHS	
WELL CHILD VISITS – 2 VISITS PER YEAR PER CHILD FROM 12 MONTHS TO 24 MONTHS	
DAILY IN-PATIENT DRUG & ALCOHOL INDEMNITY BENEFIT	
BENEFIT PER DAY OF CONFINEMENT IF MEMBER IS CONFINED IN A REHABILITATION FACILITY FOR SUBSTANCE ABUSE	$300
ANNUAL MAXIMUM BENEFIT:	$10,000
LIFETIME MAXIMUM OF $30,000	
DAILY IN-PATIENT MENTAL & NERVOUS INDEMNITY BENEFIT	
BENEFIT PER DAY OF CONFINEMENT IF MEMBER: IS CONFINED IN A REHABILITATION FACILITY FOR MENTAL OR NERVOUS DISORDERS	$300
ANNUAL MAXIMUM BENEFIT:	$10,000
LIFETIME MAXIMUM OF $30,000	
EXPRESS SCRIPTS RX CARD BENEFIT	
Co-Pay prescription card – AWP less 12%-16% discount Then a 50% copay per prescription up to an annual Benefit per member of $500 then an Express Scripts Discount plan beyond there – no pre-existing exclusions	$500
GROUP TERM LIFE POLICY WITH ACCIDENTAL DEATH AND DISMEMBERMENT RIDER ATTACHED	
PRIMARY MEMBER BENEFIT:	$5,000
SPOUSE:	$2,500
CHILD(REN) – NOT COVERED FOR AD&D BENEFIT	$2,500

DEFINITIONS

The defined terms below are subject to the provisions of the Policy and of this Certificate:

Accident or Accidental Injury: a sudden, unexpected and unintended injury:

- This is independent of any Sickness; and
- That is caused by or the result of external means; and
- That takes place while the Covered person's coverage is in force.

Active Service: You are:

- Performing in the usual manner all of the regular duties of Your occupation on a scheduled work day; or are able to perform your normal work schedule if currently not employed; and

You are said to be in Active Service on a day which is not a scheduled work day only if You would be able to perform in the usual manner all of the regular duties of Your occupation if it were a scheduled work day,

Amendment, Endorsement or Rider: Any form issued by Us which adds, modifies, changes or deletes any Policy or Certificate provisions or benefits.

Application or Enrollment Form: The form completed and signed to apply for the health benefit coverage.

Calendar year or Year: The period from January 1 through December 31 of the same year.

Certificate: The document that describes your hospital indemnity benefits coverage.

Child: A child of Yours who is unmarried; under the age of 19; dependent upon you for more than 50% of his/her support and maintenance; who lives with You; and is:

- A natural Child; or
- A legally adopted Child or a Child who has been placed for adoption with you; or
- A stepchild or foster Child; or
- A child for whom You have been appointed legal guardian; or
- A Child not living with You, but for whom you are legally required to provide support.

"Child" also includes a Child who meets the criteria described above, but who is age 19 or older, if the Child is:

- A full-time student at an accredited educational institution, college, university, vocational institution, trade school, or secondary institution, and is under the age of 24; or
- Becomes incapable of self-support because of mental retardation or physical impairment while covered and prior to reaching the limiting age of a Child. The child must be dependent on You for support and maintenance. We must receive proof of incapacity within 31 days after coverage would otherwise terminate. Then, coverage will continue for as long as Your benefits stay in force and the Child remains incapacitated. Additional proof may be required from time to time, but no more often than once a year after the Child attains the age of 24.

The term "Child" does not include a child who engages in any employment or business for compensation, profit or gain for 30 or more hours per week, unless such child is a full-time student as described above.

Confinement or Confined: That period of time the Covered Person is admitted into a medical facility on an inpatient basis in excess of 23 hours. Confinement does not include that period of time during which a Covered person is in a Hospital emergency room, an observation room, or a freestanding surgical facility or outpatient facility. Successive Confinements separated by 30 days or less will be considered as one Confinement.

Covered Person: Any or all of the following: You, You're Spouse or Your Children, who has been accepted by Us for coverage.

Critical Illness: Any of the following conditions:

1. Cancer – A disease which is identified by the presence of a malignant tumor characterized by uncontrolled growth and spread of malignant cells, and the invasion of normal tissue. Cancer must be positively identified and diagnosed with histopathological conformation. Leukemia and Hodgkin's disease (except stage 1 Hodgkin's disease) will be considered Cancer.

- Cancer does not include
    - Pre-Malignant conditions or conditions with malignant potential;
    - Prostatic cancers which are histologically described as TNM Classification T1 (including T1 (a) or T1 (b), or of other equivalent or lesser classifications).

2. Skin Cancer – Basel cell epithelioma or squamous cell carcinoma. Skin cancer does not include malignant melanoma or mycosis fungoides.
3. Carcinoma in situ – Cancer that is diagnosed with histopathological confirmation and confined to the site of the origin without having invaded neighboring tissue.
4. Heart Attack [the death (infarction) of a portion of heart muscle as a result of inadequate blood supply. The diagnosis must be based on all of the following criteria:
    - a) Associated new electrocardiographic (EKG) changes consistent with Injury;
    - b) Elevation of Cardiac enzymes; and
    - c) Confirmatory imaging studies such as thallium scans, MUGA scans or stress echocardiograms.
5. Stroke – A cerebrovascular event resulting in permanent neurological damage, including infarction, hemorrhage or embolizations of brain tissue from an extracranial source. The diagnosis must be based on:
    - Documented neurological deficits; and
    - Confirmatory neuron-imaging studies

    Stoke does not include cerebral symptoms due to:
    - Transient ischemic attack (TIA);
    - Reversible neurological deficit;
    - Migraine;
    - Cerebral injury resulting from trauma or hypoxia; or
    - Vascular disease affecting the eye, optic nerve or vestubular functions.
6. End Stage Renal Failure – Chronic, irreversible failure of the function of both kidneys, such that a Covered person must undergo regular hemodialysis or peritoneal dialysis at least weekly.
7. Major Organ Transplant Surgery – A Covered person undergoing surgery as a recipient of a human to human transplant of a heart, lung, kidney or pancreas.

Dependent – Your Child or Spouse as defined by the Certificate

Disability or Disabled – The inability, due to an injury or sickness to perform all of the substantial and material duties of your regular occupation.

For a Dependent Child or Spouse: "Disabled" means the inability to perform a majority of the normal activities of a person of like age in good health.

Effective Date – The date coverage is in effect is shown on the Schedule of Benefits. The effective date will start at 12:01 AM at the main place of business of the Policyholder.

Grace Period – The period of 31 days allowed for each dues payment after the first dues are paid.

Group Master Policy or Policy: The complete contact of benefits, which includes the Policy as issued to the Policyholder, as well as any Certificates issued to covered members, including any Amendments, Endorsement, Riders, Applications or Enrollment Forms signed by the Policyholder and each member.

Policyholder – The entity named on the Cover Page of the Policy

Hospital – A licensed institution that has on its premises or in facilities available to the Hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly Licensed Physicians.

1. Laboratory, X-ray equipment and operating rooms where major surgical operations may be performed by licensed Physicians.
2. Permanent and full-time facilities for the care of overnight resident bed patients under the supervision of a licensed Physician.
3. 24-hour-a-day nursing service by graduate registered nurses; and
4. A patient's written history and medical records.

The term "Hospital" does not include any institution used by the Covered Person as:

1. A place for rehabilitation;
2. A place for rest, or for the aged;
3. A nursing or convalescent home;
4. A long term nursing unit or geriatrics ward; or
5. An extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

Immediate Family Member – You, Your Spouse, Child, mother, father, and brother, sister or other close family member of the Covered person.

Injury or Off-the-Job injury - An injury which is caused by an Accident, and does not occur while in the course of any legal or illegal occupation, activity or employment for pay, benefit or profit.

Member– The employee or member covered for these benefits and named on the Cover page of this Certificate,

Intensive Care Unit – A specially designated area of a Hospital that provides the highest level of medical care restricted to those patients who are critically ill or critically injured. It must be separate and apart from the surgical recovery room and other rooms, wards, or beds normally used for patient confinement. It must also:

1. Be provided with constant and continuous nursing care by nurses assigned to it on a full-time basis; and
2. Be under the full-time direction and/or supervision of either a Physician or a standing committee of the Hospital's medical staff; and
3. Contain special life saving equipment.

Intensive Care Unit includes: Intensive cardiac and coronary care units, neonatal intensive care units, and burn intensive care units if such units meet the conditions in this definition. This does not include any lesser treatment units.

Physician – A licensed practitioner of the healing arts who:

1. Performs only those services permitted by his or her license; and
2. Is not an immediate Family member.

Pre-Existing Condition – A Sickness or physical condition for which the Covered person:

1. Had treatment;
2. Incurred Expense;
3. Took medications; or
4. Received a Diagnosis or advice from a Physician.

During the 12 month period immediately before the Effective Date of the Covered Person's coverage.

The term "Pre-existing" will also include a condition that manifests itself in a way that would cause an ordinary prudent person to seek medical advice, diagnosis, care or treatment.

Schedule of Benefits or Schedule – The benefit schedule set forth in this Certificate.

Sickness – An illness or disease which first manifests itself while the Covered person's coverage is in force and is the direct cause of the loss.

Spouse – Your legally married Spouse named in the Application or Enrollment Form. If you are not legally married, "Spouse" may include your common law spouse if named in the Application or Enrollment Form and if legally recognized in the state in which you reside.

Testing Day – The day on which one or more diagnostic X-rays or laboratory tests are performed.

Waiting Period – The period of time from your date of membership that must expire before you are eligible to enroll for coverage, as specified in the Policyholder's Application.

We, Us, or Our – The Insurer that underwrites this coverage.

You, Your, or Yours – The Covered Person.

ELIGIBILITY AND EFFECTIVE DATE

Effective dates are shown on the Schedule of Benefits. Coverage will start on such date at 12:01 AM at the main place of business of the Policyholder. Effective dates for all persons added to coverage after this Certificate is issued will be shown on the Schedule of Benefits issued at the time of the addition.

Employer or Member Eligibility – To be eligible for health benefits, You must:

1. Meet eligibility requirements as selected on the Policyholder's Application;
2. Satisfactorily answer all eligibility and other questions on the Application or Enrollment Form.
3. Be eligible to work. Either as a business owner, independent contractor, works for a small business or a member of a workers union.

Employee or Member Effective Date – Your benefits will take effect on the Effective Date of the Policy if:

1. You completed an Application or Enrollment Form on or before the effective date; and
2. You are in Active Service; and
3. Your first dues payment is paid and received by Us.

If you are not eligible for this coverage on the Policy effective date, Your coverage will take effect on the first day of the day which coincides with or next follows the date You first become eligible and are approved for coverage. Additionally, Your first dues payment must have been received by Us, and all provisions listed in the Employee or Member Eligibility provision above, must be met.

If you are disabled on what otherwise would be the effective date, Your coverage will be deferred until the first of the month following the date you cease to be disabled.

Dependent Eligibility – If Dependent coverage is available, A Dependent will be eligible for such coverage on the later of the following dates:

1. The day you become eligible for coverage; or
2. The day he/she first meets the definition of Dependent.

You may elect dependent coverage by:

1. Applying for Dependent coverage within 31 days of the date the dependent becomes eligible; and
2. Completing any required forms for payroll deduction or drafting of your account for payment

You must complete an Application for Enrollment of a Spouse or Child, and pay any required dues within 31 days of the date Your Spouse or Child meets these eligibility criteria. If such Application is not made within that 31 day period Your Spouse or Child will be considered a late enrollee and may be required to submit satisfactory Evidence of approved eligibility in order for coverage to become effective.

Any eligible Dependent who does not become a covered person on your effective date may be added to this Certificate subject to:

1. The Completion of an Application or Enrollment Form;
2. Satisfaction of any Evidence of eligibility requirements; and
3. Payment of any additional dues, if required.

If you and your spouse are both eligible as an employee or member, the Children may be covered as Dependents of either You or your Spouse but not both

Dependent Effective Date – The effective date of coverage for each eligible Dependent will be on the first day of the month that coincides with or next follows:

1. Our acceptance of the Application or Enrollment Form; and
2. Our receipt of the first dues payment.

However, if on such date Your coverage has not yet taken effect, the effective date for dependent coverage will be the same as your effective date.

If a Dependent is Disabled on the date coverage (with respect to that particular Dependent) would otherwise be in effect, the coverage for that Dependent will be deferred until the first of the month following cessation of Disability for that Dependent.

Newborn Child Effective Date – A newborn Dependent Child will become eligible for coverage automatically on the day he or she is born, so long as your coverage is in force on that date. Coverage includes premature babies, congenital defects and birth abnormalities. The Dependent newborn child's coverage will not continue past the 31 day period following the date of birth, unless:

1. You have notified Us by the end of the 31 day period of the addition of such newborn Child, and
2. You have paid any applicable additional dues.

BENEFIT PROVISIONS

Subject to the provisions of this certificate, and any maximum benefit limitations stated on the schedule of benefits, we will pay a benefit for a covered loss that occurs while the covered person is active under the policy, subject to extension of Benefits Provision. Please see the Schedule of Benefits for the benefit amount details for each benefit listed below.

Daily In-Hospital Indemnity Benefit – If a Covered Person is confined in a hospital as a result of Accident or Sickness, We will pay the benefit amount per day shown on the schedule. Each day must include an overnight stay for which a Hospital charge is made. No benefit will be paid for any day the Covered Person is not under the regular care and attendance of a Physician.

Surgical and Anesthesia Indemnity Benefit – If a Covered Person undergoes a surgical procedure listed on the Table of Surgical Indemnity Benefits Schedule ("Surgical Table"), as a result of a covered Accident or Sickness, We will pay the benefit shown on that Surgical table. We will also pay the benefit amount, if shown on the Schedule of Benefits, for the administration of anesthesia per surgical visit by a Physician in connection with the surgery.

If two or more procedures are performed through the same incision or operative field, the benefit paid will be for only the procedure that has the larger benefit If more than one procedure is performed, but each through a separate incision or in the separate operative field, the amount payable will be the specified amount for the primary procedure plus 50% of the amount payable for all other surgical procedures performed.

Representative surgeries have been listed in the Surgical Table. We will pay all surgeries in accordance with that Surgical Schedule. With respect to surgical procedures that are not listed in the Surgical Schedule, We will pay an indemnity benefit that is consistent with similar procedures within the Surgical Schedule.

Outpatient Physician Officer Visit Indemnity Benefit – We will pay this benefit as shown on the Schedule for a physician office visit as a result of an Accident or Sickness.

Off-the-Job Accidental Injury Benefit - We will pay benefits for the actually charges incurred for a covered Accident up to the amount shown on the Schedule for each Covered Person, for x-rays used to diagnose an Accidental Injury and treatment of a covered accident by a Physician in the Physician's officer, clinic, or urgent care facility or Hospital emergency room. Treatment must be received within 72 hours of such Accident for benefits to be payable. For purpose of this benefit only, "actual charges" will mean the amount actually paid by or on behalf of the Covered Person and accepted by a Hospital or Physician for services provided.

Critical Illness Indemnity Benefit – The Critical Illness Indemnity Benefit is payable only one time for each Covered Person, and will be paid in addition to any other benefit in this certificate. A Benefit is payable for any one of the following:

Critical Illness – We will pay the amount shown on the Schedule for each Covered Person when he/she is first diagnosed as having a covered Critical Illness.

Skin Cancer – We will pay the amount specified on the Schedule for each Covered Person when he/she is first diagnosed with Skin cancer.

Carcinoma In Situ – We will pay the amount specified on the Schedule for each Covered Person when he/she is first diagnosed as having Carcinoma In Situ.

EMERGENCY ROOM SICKNESS BENEFIT INDEMNITY BENEFIT – We will pay the benefit amount specified on the Schedule for Emergency room sickness or illness up to the number of visits shown as the maximum annual benefit.

DAILY IN-PATIENT DRUG & ALCOHOL INDEMNITY BENEFIT – We will pay the maximum daily benefit listed in the schedule of benefits for a member who is admitted into a rehabilitation facility for the treatment of drug and alcohol abuse up to the maximum of $10,000 per year benefit and $30,000 lifetime benefit. The member must be under the care of a licensed physician

BENEFIT PROVISIONS (Continued)

DAILY IN-PATIENT MENTAL & NERVOUS INDEMNITY BENEFIT – We will pay the maximum daily benefit listed in the schedule of benefits for a member who is admitted into a rehabilitation facility for the treatment of mental and nervous disorders up to the maximum of $10,000 per year benefit and $30,000 lifetime benefit. The member must be under the care of a licensed physician

Subsequent Critical Illness Indemnity Benefit – We will pay this benefit, in the amount specified on the Schedule of Benefits, when a Covered Person is first diagnosed as having a subsequent and separate covered Critical Illness. The subsequent Critical Illness must be a Critical Illness that is defined in a separate category of conditions than the first covered Critical Illness; the subsequent and separate covered Critical Illness must first manifest itself, and be diagnosed more than 60 days after the first covered Critical Illness is initially diagnosed. This subsequent Critical Illness benefit is payable only one time for each Covered Person, and will be paid in addiction to any other benefit in this Certificate. This subsequent Critical Illness Benefit is not payable for Carcinoma In Situ or Skin Cancer.

Wellness Indemnity Benefit – We will pay this benefit as shown on the Schedule for each Covered Person who has undergone the following: physical examinations, mammograms, Pap smears, immunizations, flexible sigmoidoscopy, prostate-specific antigen tests and blood screenings. Services must be under the supervision of or recommended by a Physician, and a charge must be incurred.

Intensive Care Indemnity Benefit – If a Covered Person is confined in an Intensive Care Unit as a result of Accident or Sickness, We will pay the benefit amount per day shown on the Schedule. Each day must include an overnight stay for which a Hospital charge is made. No benefit will paid for any day the Covered Person is not under the regular care and attendance of a Physician.

Physical Examinations and Autopsy – We have the right to have a Covered Person examined by a Physician of Our choice as often as reasonably necessary while a claim is pending. We will pay for such examination. In case of death, we may request an autopsy where it is not forbidden by law.

Proof of Loss – Satisfactory written Proof of Loss must be given to Us at Our Administrative Office. In case of a claim for loss for which a period payment is provided contingent upon continuing loss, each satisfactory written Proof of Loss must be sent within 90 days after the termination of the period for which we are liable. For any other loss, proof must be sent within 90 days after the date of said loss. Satisfactory written proof of loss includes but is not limited to: itemized Physician or Hospital bills, and, with regard to Critical Illness benefits, the initial pathology report diagnosing a Critical Illness.

Failure to furnish such proof within such time will not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof and that it was furnished as soon as it was reasonably possible. In any event, the proof required must be given no later than one year from the date of loss, unless the claimant was legally incapacitated.

Time of Payment of Claims – benefits for a covered loss will be paid after We receive satisfactory written Proof of Loss.

EXCLUSIONS AND LIMITATIONS

With respect to all the benefits provided under this Certificate, no benefits will be payable as the result of:

1. Suicide or any attempt thereof, while sane or insane;
2. Any Intentional self-inflicted Injury or Sickness;
3. Rest care or rehabilitative care and treatment (unless provided as a benefit on the Schedule of Benefits);
4. Immunization shots and routine examinations such as: physical examinations, mammograms, Pap smears, immunizations, flexible sigmoidoscopy, prostate-specific antigen tests and blood screenings (unless the Wellness Indemnity Benefit is shown the Schedule of Benefits);
5. Routine newborn care (unless covered under the Wellness Indemnity Benefit on the Schedule of Benefits);
6. The treatment of:
    a. Mental illness, functional or organic nervous disorder, regardless of cause (unless the Daily In-Patient Mental and Nervous Benefit is shown the Schedule of Benefits):
    b. Alcohol abuse or drug use, unless such drugs were taken on the advice of a Physician and taken as prescribed (unless the Daily In-Patient Drug and Alcohol Benefit is shown the Schedule of Benefits);
7. Participating in a riot, civil commotion, civil disobedience, or unlawful assembly;
8. Committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation;
9. Participation in:
    a. An organized contest of speed;
    b. Parachuting;
    c. Parasailing;
    d. Bungee Jumping; or
    e. Hang Gliding;
10. Air travel, except:
    a. As a fare-paying passenger on a commercial airline on a regularly scheduled route; or.
    b. As a passenger for transportation only and not as a pilot or crew member;
11. Any accident caused by the participation in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician or taken according to the Physician's instructions) or while intoxicated (intoxicated means that condition as defined by the law of the jurisdiction in which the Accident occurred);
12. Any procedure or treatment to change physical characteristics to those of the opposite sex and other treatment related to sex change;
13. The reversal of a tubal ligation or vasectomy;
14. Artificial insemination, in vitro fertilization, and test tube fertilization, including an relate testing, medications or Physician's services, unless required by law;
15. Any loss incurred while on active duty status in the armed forces (if You notify us of such active duty, we will refund any premiums paid for any period for which no coverage is provided as result of this exception.);
16. Accident or Sickness arising out of and in the course of any occupation for compensation, wage or profit OR expenses which are payable under Occupational Disease Law or similar law, whether or not application for such benefits has been made;
17. Air or ground ambulance transportation (unless the Ambulance Benefit is shown on the Schedule);
18. Routine eye examinations or fitting of eye glasses;
19. Hearing aids or fitting of hearing aids;
20. Dental examinations or dental care other than expenses resulting from an Accident;
21. Care or treatment of an Accident or Sickness not specifically provided for in this plan;
22. With respect to the Off-the-Job Accidental Injury Benefit only, charges that the Covered Person is not legally required to pay, or charges which would not have been made if this coverage had not existed; or
23. Treatment of an Accident or Sickness made necessary by or arising from war, declare or undeclared, or any act of war.

DUES

All dues are payable on or before the date they are due. You must pay any required contribution to the Policyholder.

We have the right to change the dues rates on any dues due in accordance with the terms of the Policy. If the rates are changed, We will give at least a 31-day advance written notice to the Policyholder. If an increase takes place on a day other than a due's due date, a pro rata due for the increase will be due on the next due's due date. The pro rata dues will be for the period from the date of the increase to the next dues due date. If such dues are not paid when due the coverage will automatically be terminated as of the date the pro rate dues was due. Any partial payment of dues will be refunded.

If the dues increase because a change in benefits increase Our liability, dues rates may be changed on the date that Our liability is increased, without regard to any dues rate guarantee.

TERMINATION OF HEALTH BENEFITS

Your health benefits will cease on the earliest of:

1. The last day of the payroll deduction period during which You can cease to be eligible for coverage;
2. The end of the last period for which dues payment has been made to Us;
3. The date the policy terminates; or
4. The last day of the payroll deduction period during which You terminate employment.
5.

The health benefits on a Dependent will cease on the earliest of:

1. The date Your coverage terminates;
2. The end of the last period for which dues payment has been made to Us;
3. The date of the Dependent no longer meets the definition of Dependent; or
4. The date the Policy is modified so as to exclude Dependent coverage.

We will have the right to terminate the coverage of any Covered Person who submits a fraudulent claim under the Policy.

Extension of Benefits – Whenever termination of coverage under this section occurs due to the termination of Your employment or membership such termination will be without prejudice to:

1. Any Hospital Confinement which commenced while coverage was in force, with respect to Daily In-Hospital Indemnity Benefits; or
2. Any covered treatment or service for which benefits would be provided and which commenced while coverage was in force; provided, however, that the Covered Person is and continues to be Hospital Confine or Disabled.

Such Extension of Benefits will continue for up to the earlier of:

1. 30 days; or
2. The date on which the Covered Person is no longer disabled.

CLAIMS PROVISIONS

Claim Forms – Claims forms should be used for filing Proof of Loss. We will send such form to claimant within 15 days of receipt of notice of claim. If we fail to supply the proper claim forms within 15 days, You can give proof in writing, setting for the nature and extent of loss within the time stated in the Proof of Loss Provision.

Claims Procedure – Due Proof of Loss must be submitted to us at our administrative Office. You or a personal representative may obtain a claim form by calling Our toll-free telephone number listed on the Cover Page.

Notice of Claim – Written notice of claim must be given to Us at Our Administrative Officer, or to Our agent. Such notice should be made within 30 days after any loss covered by the Policy. If it is not reasonably possible to give notice within that time, the claim may not be denied or reduced due to delay.

Payment of Benefits – Benefits may be assigned to the provider(s) of such benefits. Otherwise, provided you send us proof of payment to the providers all benefits payable under the Policy will be paid to You. Accrued benefits that are not paid at Your death will be paid to Your estate. We may pay up to $1,000.00 of such benefit to one of Your relatives at Our discretion. Such payment fully discharges Us to the extent of the payment.

GENERAL PROVISIONS

Changes to this Certificate – Only Our President, Vice-President, Secretary or an Assistant Secretary may make any changes to this Certificate and then only in writing. No agent or Policyholder has authority to change the Policy of this Certificate or to waive any of its provisions. Any changes are subject to the laws of the governing jurisdiction.

Entire Contract – The entire Contract consists of the Policy, the Certificate, any attached Amendments, Endorsements, or Riders, the Policyholder's Application, Your Applications and any Enrollment forms.

Grace period – A grace period of 31 days will be allowed for each dues payment after the first dues are paid. Coverage will stay in force during this period. The coverage under the Policy and/or Certificate will terminate at the end of the Grace Period if the premium has not been paid. You must still pay all unpaid dues. This includes the dues due for the Grace Period.

If coverage is canceled on a dues due date and the dues have been paid through that date, the Grace period will not apply. If coverage is canceled during the Grace Period, you will be liable for any unpaid dues including the pro rata premium for that part of the Grace Period which coverage was in force. Benefits may be reduced by the amount of any due, but unpaid premium.

Legal Action – No legal action may be brought to recover under the Policy and or Certificate:

1. Within 60 days after proof of Loss has been furnished as required; or
2. More than three years from the time written Proof of Loss is required to be furnished.

Misstatement of Age – If the covered person's age has been misstated, the covered persons true age will be used to adjust the dues or adjust the benefits paid.

No Dividends Payable – This Certificate does not participate in the profits or surplus earnings of Our Company.

Right to Contest – We will not use any statement, except fraudulent statements, to void or reduce benefits after this Certificate has been in force during your lifetime for two years from the effective date of coverage. Any such statement would have to be in a signed form. This also applies to all riders. Any increase in benefit amounts would be subject to a new two year contestable period for the increased amount only.

All statements made are considered representations and not warranties. No such statement will be used in any contest, unless a copy of such statement has been furnished to you.

When Notice is Given to Us – Any notice to You will be sent to your last known address.

IMPORTANT INFORMATION TO POLICYHOLDERS

In the event you need to contact anyone about this policy for any reason, please contact your cutomer service representative. If you have additional questions you may contact us at the following address and telephone number:

ATA Administrators
4676 Highway 41 North
Springfield, TN. 37172
(800) 591-6764

All of the above information relates to the Limited Benefit Hospital Indemnity Policy issued to your Policyholder

The Association provides additional benefits which are described and outlined in the material you will receive. Please be aware that not all the Association benefits are underwritten and many are discount programs offered to you as a member of the Association.

ACCIDENT MEDICAL
IN-HOSPITAL ACCIDENT ONLY
ACCIDENTAL DEATH AND DISMEMBERMENT

SCOPE OF COVERAGE

We will provide the benefits described in this certificate to all Covered Persons who suffer a covered loss which is within the scope of the DESCRIPTION OF BENEFITS PROVISIONS and results, directly and independently of all other causes, from bodily injury which is suffered in an Accident, and occurs while the person is a Covered Person under this certificate and is within the scope of the risks set forth in the DESCRIPTION OF HAZARDS provisions.

COVERED PERSONS include all members and their lawful spouses under age 70.

Accident means a sudden, unforeseeable external event which causes injury to one or more Covered Persons and occurs while coverage is in effect for the Covered Person.

THIS IS A LIMITED ACCIDENT ONLY BENEFIT. IT IS ACCIDENT ONLY CERTIFICATE AND DOES NOT COVER LOSS OR EXPENSE RESULTING FROM SICKNESS, DISEASE, OR BODILY INFIRMITY. In order to receive benefits, a COVERED person must sustain an injury while the CERTIFICATE is in force and such injury directly or independently causes a loss covered by the plan.

Benefits are payable for Eligible Expenses for non-work related injuries on the following basis:

DESCRIPTION OF BENEFITS

BENEFIT AMOUNT: $25,000 DEDUCTIBLE: $1,000 PER INJURY

If, as a result of injury, an insured incurs covered expenses starting within 90 days from the date of the accident causing the injury, we will pay, less the deductible as shown above and not to exceed the maximum benefit amount shown therein, all covered expenses incurred within one year from such date.

Covered expenses mean the usual, reasonable and customary charges for local professional ambulance service to or from a hospital and/or surgical center as well as the following usual, reasonable and customary charges for treatment, services and supplies provided or prescribed by a Doctor:

(1) Hospital Room & Board, or Surgical Center care and treatment; (2) Outpatient Hospital Emergency room; (3) Surgical Benefits; (4) Doctor's Visits In-Hospital; (5) Doctor Visits Out-Patient; (6) X-ray and Laboratory; (7) Nursing care; (8) Physiotherapy; (9) Ambulance (10) Medical Equipment Rental Charges; (11) Medical Services and Supplies (Blood, Blood transfusions, Oxygen); (12) Prescription Drugs; (13) Dental Treatment as a result of Injury to natural teeth

ACCIDENTAL DEATH & DISMEMBERMENT

Principal Sum: $50,000

If within one year from the date of an Accident covered under this certificate, Injury from such accident results in Loss listed below, we will pay the percentage of the Principal Sum set opposite the loss in the table. The amount will not exceed the Principal Sum which applies to the Covered Person.

ACCIDENT DEATH, DISMEMBERMENT, OR LOSS OF SIGHT

Loss	Percentage of Principal Sum
Loss of Life	100%
Loss of Both hands	100%
Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of One Hand	50%
Loss of One Foot	50%
Loss of Entire Sight of One Eye	50%
Loss of Thumb and Index Finger of the Same hand	25%

DISCRIPTION OF HAZARDS

24 Hour Coverage. We will pay the benefits described in this Certificate for any Accident which happens to a covered person while he is covered by this certificate. This includes travel or flight in an Aircraft with some restrictions. SEE EXCLUSIONS

GENERAL POLICY PROVISIONS

WORKERS' COMPENSATION INSURANCE: This Certificate is not in lieu of, and does not affect, any requirement for coverage under any Workers' Compensation Insurance.

EXCLUSIONS

Benefits will not be paid for a Covered person's loss which:

(1) is caused by or results from the Covered Person's own:

- (a) Intentionally self-inflicted Injury, suicide or any attempt. (In Missouri this applies only while sane);
- (b) Voluntary self administration of any drugs or chemical substance not prescribed by, and taken according to the directions of, a doctor (Accidental ingestion of a poisonous substance is not excluded);
- (c) Commission or attempt to commit a felony;
- (d) Participation in a riot or insurrection;
- (e) Driving under the influence of a controlled substance unless administered on the advice of a doctor; or
- (f) Driving while intoxicated. "Intoxicated" will have the meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs;

(2) is caused by or results from:

- (a) Declared or undeclared war or act of war;
- (b) An Accident which occurs while the Covered person is on active duty service in any armed forces. (Reserve or National Guard active duty for training is not excluded unless it extends beyond 31 days);
- (c) Aviation, except as specifically provided in this Policy;
- (d) Sickness, disease, bodily or mental infirmity or medical or surgical treatment

Bacterial or viral infection, regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of an accidental External bodily injury or accidental food poisoning.

(e) Nuclear reaction or the release of nuclear energy. However, this exclusion will not apply if the loss is sustained within 180 days of the initial incident and;

(i) The loss was caused by fire, heat, explosion or other physical trauma which was the result of the release of nuclear energy; and

(ii) The Covered Person was within a 25 mile radius of the site of the release either:
  (1) At the time of the release; or
  (2) Within 24 hours of the start of the release.

CLAIMS PROVISIONS

Written notice of claim must be given within 30 days after a covered loss occurs or as soon as reasonably possible. We will send forms to authorized members who ask for them.

Notice must be sent to the address below or call 1-800-591-6764

ATA ADMINISTRATOR
4676 HIGHWAY 41 NORTH
SPRINGFIELD, TN. 37172

PlanRx Preferred Prescription Program

You and your family can enjoy a prescription program that will save you money on virtually every prescription medication you may need. Our program offers you the following benefits:

- Retail/Mail Order Generic: $10 Maximum Member Payment per 30 day supply*
- Mail-Order Brands: $50 Maximum Payment per 30 day supply**
- Preferred Pricing on brand and generic medications not included under the Maximum Payment
- Pharmacy advisory services are required. This service is designed to maximize your savings

* Generic $10 Maximum Payment available through retail or mail order
** Preferred $50 Maximum Payment available through mail-order only

Retail/Mail Order Generic

- $10 or less for a 30-day supply for most Generics
- Very liberal formulary. See exceptions below
- Obtain up to a 90-day supply at the pharmacy – if prescribed
- Most over-the-counter (OTC) medications covered when substituted for a prescription
- All major chains and most independent pharmacies are in the network
- Very liberal maximum benefit based on 80% savings off current average retail pricing

Mail-Order: Preferred Pricing (Brand or Equivalent)

- $50 or less for a 30-day supply for medications on the formulary
- Available through mail-order only
- 90-day supply typically ordered
- Preferred Pricing offered for medications not included in formulary
- Pharmacy advisory services are required. This service is designed to maximize your savings

Limitations for Eligible "Retail" Generic Medications

The PlanRx "retail" generic Maximum Payment does not include generic medications not listed on the Covered Generic Formulary, diabetic supplies, fertility agents, sexual dysfunction medications, Injectibles, anorexiants, smoking deterrent medications, hair replacement products, cosmetic alteration drugs, Retin-A and ADHD medications for individuals over the age of 18, insulin syringes and accessories. Prescriptions are filled or refilled for up to a three (3) month's supply with a limit of 100 units per 30 days. A $10.00 maximum payment is applied for each 30-day supply.

After the member's Maximum Payment is applied, PlanRx will pay up to a maximum of $50.00 for a one month supply of a covered generic medication. In addition, PlanRx will pay a maximum of $1,200 per calendar year for each individual ($300 maximum each quarter) and a maximum of $2,400 per calendar year for a family ($600 maximum each quarter) for covered generic medications at your local network pharmacy.

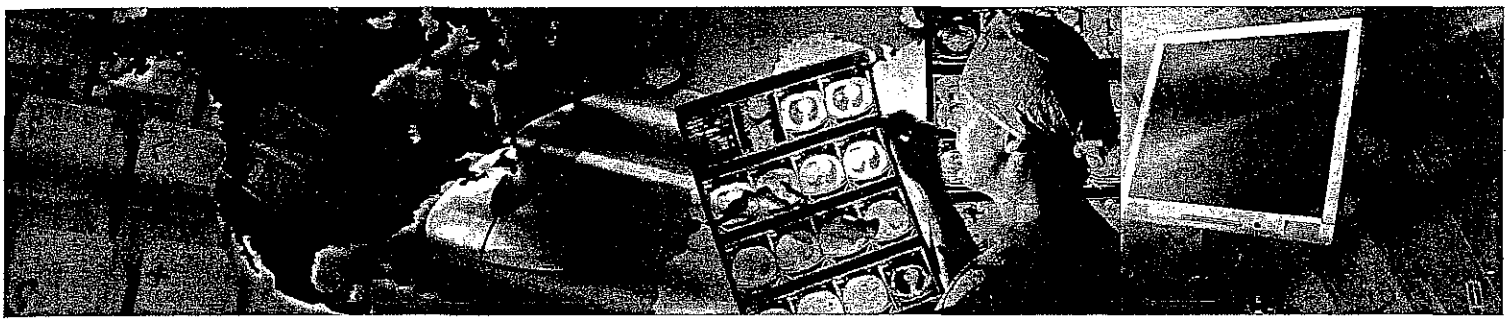
Mail-Order Medications

Preferred pricing medications are available through mail order only and generally are for a 90-day supply.

The medications included under the Maximum Payment are subject to change. It is our intent to include as many medications as possible. Any medication can be checked for preferred pricing. Mail-Order medication does not include some controlled substances and is limited to the number of units prescribed per 90-day period.

DIATRI™

CT Scan • MRI • P.E.T. Scan



Now you have the power to plug into signifcant savings on MRI, CT Scans and P.E.T. Scans

DiaTri will:

- ✓ Schedule your procedure in a facility that is convenient for you.
- ✓ Help you to prepare for your procedure by answering any questions you may have and advising you of any restrictions that may be needed.
- ✓ Give you directions to the facility.
- ✓ Notify your physician of the date and time of your test.
- ✓ Place a reminder call to you the night before your test and make sure you are set to go.
- ✓ Work with your physician to be sure they have your results in a timely manner.

You will experience substantial savings on your radiology needs.

We make sure the facilities in our network are highly credentialed and produce top quality results.

How Does it Work?

Plan members will experience up to 70% savings on MRIs, P.E.T. and CT Scans in our nationwide network of highly credentialed radiology facilities.

DiaTri Cost - Example Only

Radiology Test =	$750
Patient pays when test is scheduled =	700
DiaTri invoices Plan	$ 50

Without DiaTri

Diagnostic Facility Bills	$2000
PPO 15% Discount	300
Final Due	$1700
Plan Pays	$ 50
Member Pays	$1650

Quality Care:
DiaTri also works with your physician to ensure they know the time and place of your test and makes sure your physician receives your results in a timely manner.

To Schedule Call:
800-591-6764
Visit DiaTri at: www.diatri.net

BONUS OFFER FOR MEMBERS OF THE AMERICAN TRADE ASSOCIATION

RECIEVE UP TO $200 IN VISA® PREPAID CARDS WHEN YOU SIGN UP FOR DIRECTV.* SEE DETAILS BELOW!

Every 8 seconds someone switches to DIRECTV.

Don't be the last one to enjoy the most HD with America's #1 satellite TV service.

SAVE $26 EVERY MONTH AND LOCK IN YOUR PRICE FOR ONE FULL YEAR!

$29.99/MONTH For 12 Months* — The CHOICE™ Package

THE TV PACKAGE THAT BEATS CABLE.

- ☑ OVER 150 Digital Channels
- 9 PREMIUM CHANNELS, FOR 3 MONTHS: FREE SHOWTIME 9 Channels

BONUS $200 Visa® prepaid card! As low as*

$34.99/MONTH For 12 Months* — The CHOICE XTRA™ Package

MORE CHANNELS, MOVIES AND SPORTS!

- ☑ OVER 200 Digital Channels
- ☑ FREE HD DVR Upgrade** $199 value
- 21 PREMIUM CHANNELS, FOR 3 MONTHS: FREE starz 12 Channels + SHOWTIME 9 Channels

BONUS $200 Visa® prepaid card! As low as*

$39.99/MONTH

WATCH WHAT YOU WANT, WHEN YOU WANT.

- ☑ OVER 200 Digital Channels
- ☑ Monthly DVR Service Included
- ☑ FREE HD DVR Upgrade** $199 value
- 21 PREMIUM CHANNELS, FOR 3 MONTHS: FREE starz 12 Channels + SHOWTIME 9 Channels

BONUS $200 Visa® prepaid card! As low as*

*Prices include a $21 bill credit for 12 months after rebate, plus an additional $5 when you submit rebate online, register account on directv.com with valid email and consent to email alerts. °When you sign up for Auto Bill Pay.

WITH EVERY PACKAGE YOU GET:

- > NO Equipment to Buy. NO Start-Up Costs.
- > FREE Professional Installation
- > 99.9% Worry-Free Signal Reliability
- > #1 in Customer Satisfaction
- > Local Channels Included: abc CBS FOX NBC PBS | CW My TV — Independent channels in select markets.

1 SWITCH NOW. Get a $100 Visa® prepaid card with DIRECTV.

2 BONUS OFFER FOR MEMBERS OF THE AMERICAN TRADE ASSOCIATION

Receive an additional $100 Visa® prepaid card with your order*

CALL 1-800-309-3049

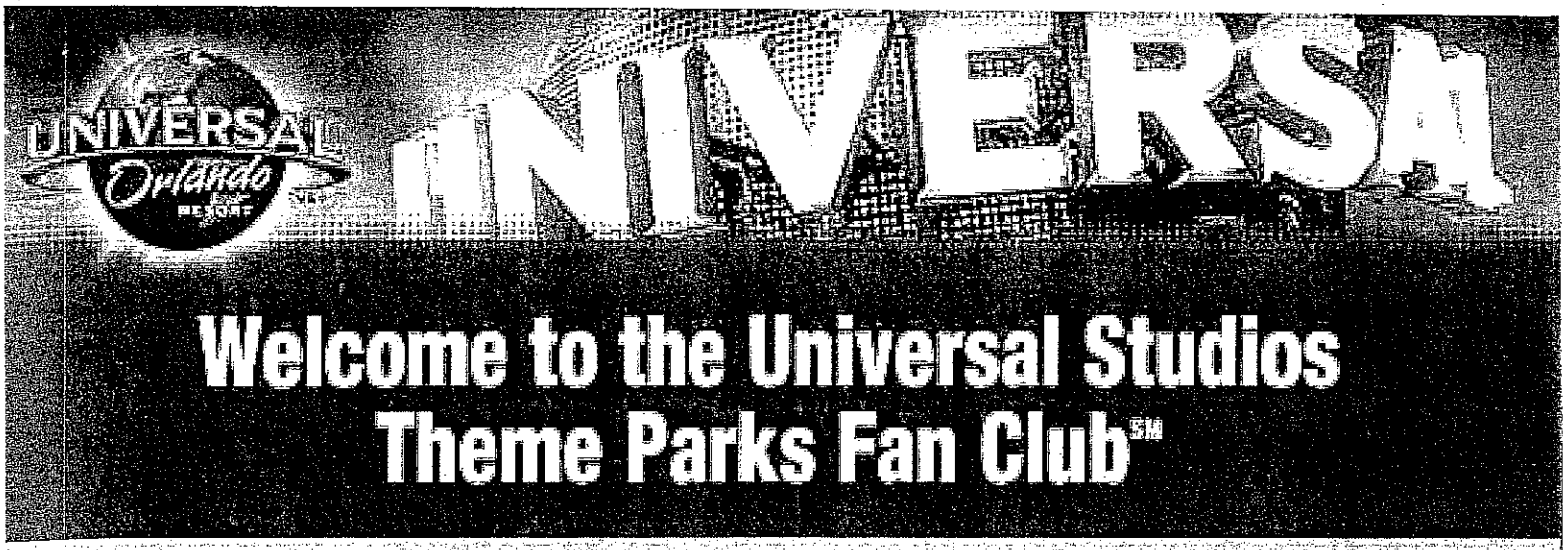
MENTION PROMO CODE ATA100

or visit www.intechmediaservices.com/directv

DIRECTV. SATELLITE TELEVISION

Offers end 2/06/10, on approved credit, credit card required. New customers only (lease required, must maintain programming, DVR and HD Access). Hardware available separately. Lease fee $5.00/mo. for second and each additional receiver. $19.95 Handling & Delivery fee may apply.

HD channel counts based on 247 HD channels. Number of HD channels varies by package. HD Access fee ($10/mo.) and HD equipment required. Eight seconds based on gross subscriber additions for 2008. Customer satisfaction measured among the largest national cable & satellite TV providers. 2009 American Customer Satisfaction Index, University of Michigan Business School. Local channel eligibility based on service address. Credit card not required in MA & PA. *BILL CREDIT/PROGRAMMING OFFER: Free SHOWTIME for 3 months, a value of $38.97. Free Starz and SHOWTIME for 3 months, a value of $72. LIMIT ONE PROGRAMMING OFFER PER ACCOUNT. Featured package names and prices: CHOICE $65.99/mo.; CHOICE XTRA $68.99/mo.; PLUS DVR $65.99/mo. Upon DIRECTV System activation, customer will receive redemption instructions (included in customer's first DIRECTV bill, a separate mailing, or, in the state of New York, from retailer) and must comply with the terms of the instructions. In order to receive full $26 credit, customer must submit rebate form online, register account on directv.com and consent to emails prior to rebate redemption. Online redemption requires valid email address. Rebate begins 6-8 weeks after receipt of rebate form online or 8 to 12 weeks by mail. Timing of promotional price depends on redemption date. Account must be in "good standing," as determined by DIRECTV in its sole discretion, to remain eligible. DIRECTV not responsible for late, lost, illegible, mutilated, incomplete, misdirected or postage-due mail. IF BY THE END OF PROMOTIONAL PRICE PERIOD(S) CUSTOMER DOES NOT CONTACT DIRECTV TO CHANGE SERVICE THEN ALL SERVICES WILL AUTOMATICALLY CONTINUE AT THE THEN-PREVAILING RATES INCLUDING THE $6.00/MO. LEASE FEE FOR THE 2ND AND EACH ADDITIONAL RECEIVER. DIRECTV System has a feature which restricts access to channels. In certain markets, programming/pricing may vary. **$100 VISA PREPAID CARD OFFER: New customers only. With activation of the CHOICE Package or higher. Customer must enroll in Auto Bill Pay program at the time of purchase. $100 Visa prepaid card will be in the form of a DIRECTV Visa® Prepaid Card mailed to active DIRECTV account. DIRECTV Visa Prepaid Cards are issued by MetaBank™ pursuant to a license from Visa U.S.A. Inc. This card does not have cash access and can be used at any merchants that accept Visa debit cards. Card valid through expiration date shown on front of card. Must maintain DIRECTV service and enrollment in Auto Bill Pay program for a minimum of 60 days with no past due balance. Visa prepaid card will be mailed within 90 days from activation date. *Additional $100 Visa Gift Card offered to qualifying customers who sign up for DIRECTV through inTech Media Services, LLC in partnership with My ATA Benefits and is not eligible for any additional offers. Gift cards will be issued to active DIRECTV account after 90 days of service with no past due balance. Gift cards are not refundable for cash. **INSTANT REBATE: Advanced equipment instant rebate requires activation of the CHOICE XTRA Package or above; Jadeworld; or any qualifying international services bundle, which shall include the PREFERRED CHOICE programming package (valued
$6.00/mo.) required for DVR and HD DVR lease; HD Access fee ($10.00/mo.) required for HD and HD DVR lease. LIMIT ONE ADVANCED EQUIPMENT REBATE PER ACCOUNT. INSTALLATION: Standard professional installation only. Custom installation extra. SYSTEM LEASE: Purchase of 24 consecutive months of any DIRECTV base programming package ($29.99/mo. or above) or qualifying international services bundle required. FAILURE TO ACTIVATE ALL DIRECTV SYSTEM EQUIPMENT IN ACCORDANCE WITH THE EQUIPMENT LEASE ADDENDUM MAY RESULT IN A CHARGE OF $150 PER RECEIVER NOT ACTIVATED. IF YOU FAIL TO MAINTAIN YOUR PROGRAMMING, DIRECTV MAY CHARGE A PRORATED FEE OF $[illegible]. RESTRICTIONS [illegible]



Welcome to the Universal Studios Theme Parks Fan Club℠

Fan Club Members save 10%

on Universal Orlando® Resort tickets and vacation packages

AND

Enjoy special vacation offers year-round!

Take A Vacation from the Ordinary® at Universal Orlando Resort, the only place where you'll find the world's two most amazing theme parks—Universal Studios®, where you can jump into the action of your favorite movies, and Universal's Islands of Adventure®, where you'll feel the adrenaline rush of the most innovative rides and attractions ever created.

Plus you can enjoy the non-stop entertainment at Universal CityWalk®, and stay at magnificently themed on-site hotels including the luxurious Portofino Bay Hotel, A Loews Hotel, the exciting Hard Rock Hotel®, and the exotic Royal Pacific Resort, A Lowes Hotel.

Build your own Universal vacation and save 10%. Select from a variety of hotel accommodations, theme park tickets, dining options, Orlando area attraction passes and more!

Savings on tickets and vacation packages can be obtained by visiting:
www.universalfanclub.com/orlando/memberbenefits/nationalfcmembers.htm

STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
312 Rosa L. Parks Avenue
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

American Trade Association, Inc
400 MEMORIAL BLVD
Springfield, TN 37172 USA

March 23, 2010

Filing Acknowledgment

Please review the filing information below and notify our office immediately of any discrepancies.

Control # :	**627202**	Formation Locale:	Robertson County
Filing Type:	Corporation Non-Profit - Domestic	Date Formed:	03/19/2010
Filing Date:	03/19/2010 9:53 AM	Fiscal Year Close	12
Status:	Active	Annual Rpt Due:	04/01/2011
Duration Term:	Perpetual	Image # :	6679-2039
Public/Mutual Benefit:	Public		

Document Receipt

Receipt # : 113697	Filing Fee:	$100.00
Payment-Check/MO - American Trade Association, Inc, Springfield, TN		$100.00

Registered Agent Address
NATIONAL REGISTERED AGENT, INC
2300 Hillsboro Road
Ste 305
Nashville, TN 37212 USA

Congratulations on the successful filing of your **Charter** for **American Trade Association, Inc** in the State of Tennessee which is effective on the date shown above. You must also file this document in the office of the Register of Deeds in the county where the entity has its principal office if such principal office is in Tennessee.

You must file an Annual Report with this office on or before the Annual Report Due Date noted above and maintain a Registered Office and Registered Agent. Failure to do so will subject the business to Administrative Dissolution/Revocation.

Tre Hargett

Tre Hargett, Secretary of State
Business Services Division

EXHIBIT
5
T.O. Heisse

State of Tennessee

Department of State
Corporate Filings
312 Rosa L. Parks Avenue
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

CHARTER
(Nonprofit Corporation)

FILED

For Office Use Only
RECEIVED
STATE OF TENNESSEE
2010 FEB 26 PM 1:57
TRE HARGETT
SECRETARY OF STATE

5553-0515 5578-2035

The undersigned acting as incorporator(s) of a nonprofit corporation under the *Tennessee Nonprofit Corporation Act* adopts the following Articles of Incorporation.

1. The name of the corporation is: American Trade Association, INC

2. Please complete all of the following sentences by checking one of the two boxes in each sentence:
   This corporation is a ☑ public benefit corporation / ☐ mutual benefit corporation.
   This corporation is a ☐ religious corporation / ☑ not a religious corporation.
   This corporation will ☑ have members / ☐ not have members.

3. The name and complete address of the corporation's initial registered agent and office in Tennessee is:

Name	Street Address	City	State	Zip Code	County
National Register Agent, Inc	2300 Hillsboro Rd,	Nashville	TN	37212	USA

4. List the name and complete address of each incorporator:

Name	Street Address	City	State	Zip Code
obed Kirkpatrick	400 memorial Blvd	Springfield,	TN	37172
Linda Kirkpatrick	400 memorial Blvd	Springfield,	TN	37172

5. The complete address of the corporation's principal office is:

Street Address	City	State/Country	Zip Code
400 MEMORIAL BLVD	Springfield	TN Robertson USA	37172

6. The corporation is not for profit.

7. If the document is not to be effective upon filing by the Secretary of State, the delayed effective date and time are:
   Date ______________, ________ Time ______________ (Not to exceed 90 days.)

8. Insert here the provisions regarding the distribution of assets upon dissolution:
   Split between members

9. Other provisions:

RECEIVED
STATE OF TENNESSEE
2010 MAR 19 AM 9:53
TRE HARGETT
SECRETARY OF STATE

2/21/10
Signature Date

[signature]
Incorporator's Signature

obed Kirkpatrick
Incorporator's Name (typed or printed)

SS-4418 (Rev. 9/04) Filing Fee: $100 RDA 1678

State of Tennessee

Department of State
Corporate Filings
312 Rosa L. Parks Avenue
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

CHARTER
(Nonprofit Corporation)

For Office Use Only

The undersigned acting as incorporator(s) of a nonprofit corporation under the *Tennessee Nonprofit Corporation Act* adopts the following Articles of Incorporation.

1. The name of the corporation is: Great American Benefit Association, Inc.

2. Please complete all of the following sentences by checking one of the two boxes in each sentence:
This corporation is a ☑ public benefit corporation / ☐ mutual benefit corporation.
This corporation is a ☐ religious corporation / ☑ not a religious corporation.
This corporation will ☑ have members / ☐ not have members.

3. The name and complete address of the corporation's initial registered agent and office in Tennessee is:

Name	Street Address	City	State	Zip Code	County
National Registered Agents, Inc.	2300 Hillsboro Rd Suite	Nashville	TN	37212	Davidson

4. List the name and complete address of each incorporator:

Name	Street Address	City	State	Zip Code

5. The complete address of the corporation's principal office is:

Street Address	City	State/Country	Zip Code
400 Memorial Blvd	Springfield	TN	37172

6. The corporation is not for profit.

7. If the document is not to be effective upon filing by the Secretary of State, the delayed effective date and time are:
Date _____, _____ Time _____ (Not to exceed 90 days.)

8. Insert here the provisions regarding the distribution of assets upon dissolution:
Divided equally among members

9. Other provisions: _____

_____ Signature Date

_____ Incorporator's Signature

_____ Incorporator's Name (typed or printed)

SS-4418 (Rev. 9/04) **Filing Fee: $100** RDA 1678

State of Tennessee

Department of State
Corporate Filings
312 Rosa L. Parks Avenue
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

CHARTER
(Nonprofit Corporation)

For Office Use Only

The undersigned acting as incorporator(s) of a nonprofit corporation under the *Tennessee Nonprofit Corporation Act* adopts the following Articles of Incorporation.

1. The name of the corporation is: _____

2. Please complete all of the following sentences by checking one of the two boxes in each sentence:
   This corporation is a ☐ public benefit corporation / ☐ mutual benefit corporation.
   This corporation is a ☐ religious corporation / ☐ not a religious corporation.
   This corporation will ☐ have members / ☐ not have members.

3. The name and complete address of the corporation's initial registered agent and office in Tennessee is:

Name	*Street Address*	*City*	*State*	*Zip Code*	*County*

4. List the name and complete address of each incorporator:

Name	*Street Address*	*City*	*State*	*Zip Code*

5. The complete address of the corporation's principal office is:

Street Address	*City*	*State/Country*	*Zip Code*

6. The corporation is not for profit.

7. If the document is not to be effective upon filing by the Secretary of State, the delayed effective date and time are:
   Date _____, _____ Time _____ (Not to exceed 90 days.)

8. Insert here the provisions regarding the distribution of assets upon dissolution: _____

9. Other provisions: _____

_____ _____
Signature Date Incorporator's Signature

_____
Incorporator's Name (typed or printed)

SS-4418 (Rev. 9/04) **Filing Fee: $100** RDA 1678

Tennessee Department of State

Entity Detail

Entity details cannot be edited. This detail reflects the current state of the filing in the system.
Click Here to return to the Business Information Search

000627202: Corporation Non-Profit - Domestic

Name:	American Trade Association, Inc		
Old Name:			
Business Type:			
Status:	Active	**Initial Filing:**	03/19/2010
Formed in:	Robertson County	**Delayed Effective Date:**	
Fiscal Year Close:	December	**AR Due Date:**	04/01/2011
Term of Duration:	Perpetual	**Inactive Date:**	
Principal Office:	400 MEMORIAL BLVD Springfield, TN 37172 USA		
AR Exempt:	No		
Public Benefit Corporation:	Yes		

Assumed Names | History | Registered Agent

Name	Status	Date	Expires
No Assumed Names Found...			

Printer Friendly Version

Division of Business Services
312 Rosa L. Parks Avenue, Snodgrass Tower, 6th Floor
Nashville, TN 37243
615-741-2286
Email | Directions | Hours and Holidays

STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
312 Rosa L. Parks Avenue
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

AMERICAN TRADE ASSOCIATION, INC.
4676 HIGHWAY 41 N
SPRINGFIELD, TN 37172 USA

March 2, 2010

Filing Acknowledgment

Please review the filing information below and notify our office immediately of any discrepancies.

Control # : 602641 Status: Inactive - Withdrawn
Filing Type: Corporation Non-Profit - Foreign

Document Receipt

Receipt # : 81701	Filing Fee:	$20.00
Payment-Check/MO - AMERICAN TRADE ASSOCIATION, INC., SPRINGFIELD, TN		$20.00

Amendment Type: Withdrawal Image # : 6663-0848
Filed Date: 02/26/2010 1:57 PM

This will acknowledge the filing of the attached withdrawal with an effective date as indicated above.

Tre Hargett, Secretary of State
Business Services Division

Field Name	Changed From	Changed To
Filing Status	Active	Inactive - Withdrawn
Inactive Date	No Value	02/26/2010

State of Tennessee

Department of State
Corporate Filings
312 Rosa L. Parks Avenue
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

APPLICATION FOR CERTIFICATE OF WITHDRAWAL

FILED

For Office Use Only
RECEIVED
STATE OF TENNESSEE
2010 FEB 26 PM 1:57
TRE HARGETT
SECRETARY OF STATE

To the Secretary of State of the State of Tennessee:

Pursuant to the provisions of Section 48-25-201 of the Tennessee Business Corporation Act or Section 48-65-201 of the Tennessee Nonprofit Corporation Act, the undersigned corporation hereby applies for a certificate of withdrawal from the State of Tennessee, and for that purpose sets forth:

1. The name of the corporation is American Trade Association, Inc.

If different, the name under which the certificate of authority was obtained is

2. The state or country under whose law it is incorporated is Indiana.

3. The corporation is not transacting business in the State of Tennessee and surrenders its authority to transact business in this state.

4. Please mark/complete the applicable statement:

☑ The corporation continues its registered agent and registered office in the State of Tennessee.

☐ The corporation hereby revokes the authority of its registered agent to accept service on its behalf and appoints the Secretary of State as its agent for service of process in any proceeding based on a cause of action arising during the time it was authorized to transact business in this state. The mailing address (including zip code) to which the Secretary of State may mail a copy of any process served on him is:

5. The undersigned corporation makes the commitment to notify the Secretary of State in the future of any change in its mailing address.

[NOTE: Prior to this document being accepted for filing, the Division of Business Services will request tax clearance verification from the Tennessee Department of Revenue that the business has properly filed all reports and paid all required taxes and penalties. If we cannot obtain such tax clearance verification from the Department of Revenue, this document will be rejected and returned to the applicant.]

2/21/10
Signature Date

American Trade Ass'n, Inc.
Name of Corporation

President
Signer's Capacity

Signature

Obed Kirkpatrick
Name (typed or printed)

SS-4437 (Rev. 8/08) NP

Filing Fee $20.00

RDA 1678

602641

Tennessee Department of State

Entity Detail

Entity details cannot be edited. This detail reflects the current state of the filing in the system.
Click Here to return to the Business Information Search

000627202: Corporation Non-Profit - Domestic

Name: American Trade Association, Inc
Old Name:
Business Type:
Status: Active
Initial Filing: 03/19/2010
Formed in: Robertson County
Delayed Effective Date:
Fiscal Year Close: December
AR Due Date: 04/01/2011
Term of Duration: Perpetual
Inactive Date:
Principal Office: 400 MEMORIAL BLVD
Springfield, TN 37172 USA
AR Exempt: No
Public Benefit Corporation: Yes

Assumed Names | History | Registered Agent

Name	Status	Date	Expires
No Assumed Names Found...			

Printer Friendly Version

Division of Business Services
312 Rosa L. Parks Avenue, Snodgrass Tower, 6th Floor
Nashville, TN 37243
615-741-2286
Email | Directions | Hours and Holidays

INDIANA SECRETARY OF STATE

RECEIPT

Receipt Number : 1736361

Payment Entry Number : 655903

INDIANA SECRETARY OF STATE
BUSINESS SERVICES DIVISION
302 West Washington Street, Room E018
Indianapolis, IN 46204
(317) 232-6576

AMERICAN TRADE ASSOCIATION INC
4676 HWY 41 N
SPRINGFIELD, TN 37172

Receipt Date: 03/02/2010
Receipt Status: Closed

The following details your transaction(s) with the Secretary of State's Office :

Payment Submitted:

Payor	Payment Type	Reference	Comment	Amount
AMERICAN TRADE ASSOCIATION INC	Check/ MO	2279		$30.00
			Total Amount :	**$30.00**

Transactions posted to this receipt:

Entity Name	Type of Filing	Amount
AMERICAN TRADE ASSOCIATION, INC.	Non-Profit Domestic Corporation : Articles of Dissolution	$30.00
	Total Amount :	**$30.00**

STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
312 Rosa L. Parks Avenue
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

AMERICAN TRADE ASSOCIATION, INC.
4676 HIGHWAY 41 N
SPRINGFIELD, TN 37172 USA

March 2, 2010

Filing Acknowledgment

Please review the filing information below and notify our office immediately of any discrepancies.

Control # : 602641 Status: Inactive - Withdrawn
Filing Type: Corporation Non-Profit - Foreign

Document Receipt

Receipt # : 81701	Filing Fee:	$20.00
Payment-Check/MO - AMERICAN TRADE ASSOCIATION, INC., SPRINGFIELD, TN		$20.00

Amendment Type: Withdrawal Image # : 6663-0848
Filed Date: 02/26/2010 1:57 PM

This will acknowledge the filing of the attached withdrawal with an effective date as indicated above.

Tre Hargett, Secretary of State
Business Services Division

Field Name	Changed From	Changed To
Filing Status	Active	Inactive - Withdrawn
Inactive Date	No Value	02/26/2010

State of Tennessee

Department of State
Corporate Filings
312 Rosa L. Parks Avenue
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

APPLICATION FOR CERTIFICATE OF WITHDRAWAL

FILED

For Office Use Only
RECEIVED
STATE OF TENNESSEE
2010 FEB 26 PM 1:57
TRE HARGETT
SECRETARY OF STATE

To the Secretary of State of the State of Tennessee:

Pursuant to the provisions of Section 48-25-201 of the Tennessee Business Corporation Act or Section 48-65-201 of the Tennessee Nonprofit Corporation Act, the undersigned corporation hereby applies for a certificate of withdrawal from the State of Tennessee, and for that purpose sets forth:

1. The name of the corporation is American Trade Association, Inc.

If different, the name under which the certificate of authority was obtained is _____.

2. The state or country under whose law it is incorporated is INDIANA.

3. The corporation is not transacting business in the State of Tennessee and surrenders its authority to transact business in this state.

4. Please mark/complete the applicable statement:

☑ The corporation continues its registered agent and registered office in the State of Tennessee.

☐ The corporation hereby revokes the authority of its registered agent to accept service on its behalf and appoints the Secretary of State as its agent for service of process in any proceeding based on a cause of action arising during the time it was authorized to transact business in this state. The mailing address (including zip code) to which the Secretary of State may mail a copy of any process served on him is:

_____.

5. The undersigned corporation makes the commitment to notify the Secretary of State in the future of any change in its mailing address.

[NOTE: Prior to this document being accepted for filing, the Division of Business Services will request tax clearance verification from the Tennessee Department of Revenue that the business has properly filed all reports and paid all required taxes and penalties. If we cannot obtain such tax clearance verification from the Department of Revenue, this document will be rejected and returned to the applicant.]

2/21/10
Signature Date

American Trade Asso, Inc
Name of Corporation

President
Signer's Capacity

Signature

Obed Kirkpatrick
Name (typed or printed)

SS-4437 (Rev. 8/08) NP

Filing Fee $20.00

RDA 1678

602641

State of Indiana
Office of the Secretary of State

CERTIFICATE OF DISSOLUTION

of

AMERICAN TRADE ASSOCIATION, INC.

I, TODD ROKITA, Secretary of State of Indiana, hereby certify that Articles of Dissolution of the above Non-Profit Domestic Corporation have been presented to me at my office, accompanied by the fees prescribed by law and that the documentation presented conforms to law as prescribed by the provisions of the Indiana Nonprofit Corporation Act of 1991.

NOW, THEREFORE, with this document I certify that said transaction will become effective Monday, March 01, 2010.

In Witness Whereof, I have caused to be affixed my signature and the seal of the State of Indiana, at the City of Indianapolis, March 1, 2010.

TODD ROKITA,
SECRETARY OF STATE

198607-273 / 2010030278027

INDIANA SECRETARY OF STATE

RECEIPT

Receipt Number : 1736361

Payment Entry Number : 655903

INDIANA SECRETARY OF STATE
BUSINESS SERVICES DIVISION
302 West Washington Street, Room E018
Indianapolis, IN 46204
(317) 232-6576

AMERICAN TRADE ASSOCIATION INC
4676 HWY 41 N
SPRINGFIELD, TN 37172

Receipt Date: 03/02/2010
Receipt Status: Closed

The following details your transaction(s) with the Secretary of State's Office :

Payment Submitted:

Payor	Payment Type	Reference	Comment	Amount
AMERICAN TRADE ASSOCIATION INC	Check/ MO	2279		$30.00
			Total Amount :	**$30.00**

Transactions posted to this receipt:

Entity Name	Type of Filing	Amount
AMERICAN TRADE ASSOCIATION, INC.	Non-Profit Domestic Corporation : Articles of Dissolution	$30.00
	Total Amount :	**$30.00**

State of Tennessee

Department of State
Corporate Filings
312 Rosa L. Parks Avenue
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

CHARTER
(Nonprofit Corporation)

For Office Use Only

The undersigned acting as incorporator(s) of a nonprofit corporation under the *Tennessee Nonprofit Corporation Act* adopts the following Articles of Incorporation.

1. The name of the corporation is: Great American Benefit Association, Inc.

2. Please complete all of the following sentences by checking one of the two boxes in each sentence:
This corporation is a ☑ public benefit corporation / ☐ mutual benefit corporation.
This corporation is a ☐ religious corporation / ☑ not a religious corporation.
This corporation will ☑ have members / ☐ not have members.

3. The name and complete address of the corporation's initial registered agent and office in Tennessee is:

Name	*Street Address*	*City*	*State*	*Zip Code*	*County*
National Registered Agents, Inc.	2300 Hillsboro Rd Suite	Nashville	TN	37212	Davidson

4. List the name and complete address of each incorporator:

Name	*Street Address*	*City*	*State*	*Zip Code*

5. The complete address of the corporation's principal office is:

Street Address	*City*	*State/Country*	*Zip Code*
400 Memorial Blvd	Springfield	TN	37172

6. The corporation is not for profit.

7. If the document is not to be effective upon filing by the Secretary of State, the delayed effective date and time are:
Date _____, _____ Time _____ (Not to exceed 90 days.)

8. Insert here the provisions regarding the distribution of assets upon dissolution:
Divided equally among members

9. Other provisions: _____

_____ _____
Signature Date Incorporator's Signature

_____
Incorporator's Name (typed or printed)

SS-4418 (Rev. 9/04) **Filing Fee: $100** RDA 1678

EXHIBIT
6
to Heiss C

State of Tennessee

Department of State
Corporate Filings
312 Rosa L. Parks Avenue
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

CHARTER
(Nonprofit Corporation)

For Office Use Only

The undersigned acting as incorporator(s) of a nonprofit corporation under the *Tennessee Nonprofit Corporation Act* adopts the following Articles of Incorporation.

1. The name of the corporation is: _____

2. Please complete all of the following sentences by checking one of the two boxes in each sentence:
   This corporation is a ☐ public benefit corporation / ☐ mutual benefit corporation.
   This corporation is a ☐ religious corporation / ☐ not a religious corporation.
   This corporation will ☐ have members / ☐ not have members.

3. The name and complete address of the corporation's initial registered agent and office in Tennessee is:

   Name | *Street Address* | *City* | *State* | *Zip Code* | *County*

4. List the name and complete address of each incorporator:

   Name | *Street Address* | *City* | *State* | *Zip Code*

   Name | *Street Address* | *City* | *State* | *Zip Code*

   Name | *Street Address* | *City* | *State* | *Zip Code*

5. The complete address of the corporation's principal office is:

   Street Address | *City* | *State/Country* | *Zip Code*

6. The corporation is not for profit.

7. If the document is not to be effective upon filing by the Secretary of State, the delayed effective date and time are:
   Date _____, _____ Time _____ (Not to exceed 90 days.)

8. Insert here the provisions regarding the distribution of assets upon dissolution: _____

9. Other provisions: _____

_____ Signature Date

_____ Incorporator's Signature

_____ Incorporator's Name (typed or printed)

UNDERWRITER: 001 THRU 999
COMBINE BY TAXID: N
SHOW EMPLOYEE DETAIL: Y

COMPENSATIONS FOR GROUP: 201 THRU 201
AND BROKER: 040 THRU 040, PAYABLES THRU 03/10/2010
BILLINGS DATED BEGINNING THRU 01/01/2010

CHECKING ACCOUNT: (ALL)

BROKER: 040 ATA MARKETING
4676 HWY 41 N
SPRINGFIELD TN 37172

JUN/GRP	BROKER GROUP	NAME	EMPLOYEE SSN	BILL DATE	COVG DATE	PROD	STATUS	DEP STATUS	PLAN	TIER	BILLED LIVES	RECEIVD PREMIUM	DESC	VOLUME	AMOUNT
001	201	AMERICAN TRADE ASSOCIATION	[redacted]	12/15/09	12/15/09	MM	ACTIVE	EE	NAT CHOIC	B	1	20.95	FEES	0	20.95
				01/01/10	01/01/10	MM	ACTIVE	EE	PLUS 500	w	1	58.26	FEES	0	58.26
				01/01/10	01/01/10	MM	ACTIVE	EE	NAT CHOIC	B	1	20.95	FEES	0	20.95
				12/15/09	12/15/09	MM	ACTIVE	EE	PLUS 500	w	1	58.26	FEES	0	58.26
				01/01/10	01/01/10	MM	ACTIVE	EE	PLUS 500	w	1	58.26	FEES	0	58.26
				01/01/10	01/01/10	MM	ACTIVE	EE	ATA2500	X	1	34.75	FEES	0	34.75
				12/15/09	12/15/09	MM	ACTIVE	EE	NAT CHOIC	B	1	20.95	FEES	0	20.95
				12/15/09	12/15/09	MM	ACTIVE	EE	PLUS 500	w	1	58.26	FEES	0	58.26
				12/15/09	12/15/09	MM	ACTIVE	EE	ATA2500	X	1	34.75	FEES	0	34.75
				01/01/10	01/01/10	MM	ACTIVE	EE	ATA5000	d	1	49.75	FEES	0	49.75
				01/01/10		XX					0	125.00	MISC FEES	0	125.00
				01/01/10	01/01/10	MM	ACTIVE	Fam	PLUS 500	w	1	83.42	FEES	0	83.42
				01/01/10	01/01/10	MM	ACTIVE	EE+Sp	PLUS 500	w	1	80.56	FEES	0	80.56
				12/15/09	12/15/09	MM	ACTIVE	Fam	NAT CHOIC	B	1	20.95	FEES	0	20.95
				11/15/09	11/15/09	MM	ACTIVE	EE+Ch	NAT CHOIC	B	1	20.95	FEES	0	20.95
				12/15/09	12/15/09	MM	ACTIVE	EE+Ch	NAT CHOIC	B	1	20.95	FEES	0	20.95
				12/15/09	12/15/09	MM	ACTIVE	EE+Sp	NAT CHOIC	B	1	20.95	FEES	0	20.95
				01/01/10	01/01/10	MM	ACTIVE	EE	ATA7500	h	1	49.75	FEES	0	49.75
				01/01/10	01/01/10	MM	ACTIVE	EE	ATA2500	X	1	34.75	FEES	0	34.75
				01/01/10	01/01/10	MM	ACTIVE	EE	ATA2500	X	1	34.75	FEES	0	34.75
				01/01/10	01/01/10	MM	ACTIVE	EE	ATA7500	h	1	49.75	FEES	0	49.75
				12/15/09	12/15/09	MM	ACTIVE	EE+Sp	ATA7500	h	1	9.75	FEES	0	9.75
				01/01/10	01/01/10	MM	ACTIVE	EE	ATA7500	h	1	49.75	FEES	0	49.75
				12/15/09	12/15/09	MM	ACTIVE	Fam	ATA7500	w	1	77.75	FEES	0	77.75
				01/01/10	01/01/10	MM	ACTIVE	EE	ATA2500	X	1	34.75	FEES	0	34.75
				01/01/10	01/01/10	MM	ACTIVE	EE	ATA2500	f	1	77.75	FEES	0	77.75
								***	GROUP	TOTAL:		1206.67		0	1206.67

EXHIBIT 7 to Reiss

UNDERWRITER: 001 THRU 999 COMPENSATIONS FOR GROUP: 201 THRU 201 CHECKING ACCOUNT: (ALL)
COMBINE BY TAXID: N AND BROKER: 040 THRU 040, PAYABLES THRU 03/10/2010
SHOW EMPLOYEE DETAIL: Y BILLINGS DATED BEGINNING THRU 01/01/2010

BROKER NAME		EMPLOYEE	BILL	COVG		DEP			BILLED	RECEIVD			
PUN/GRP	GROUP NAME	SSN	DATE	DATE	PROD STATUS	STATUS	PLAN	TIER	LIVES	PREMIUM	DESC	VOLUME	AMOUNT
								*** BROKER TOTAL:		1206.67		0	1206.67
								***** GRAND TOTAL:		1206.67		0	1206.67

ATA Payout Report: 02/15/2010

MEMBER I	FIRST NAM	LAST NAME	TRANS ID	FUND DATE	CREATED DA	BILLED DATE	BILLI	METHO	TYPE	AMT BIL	PLAN	SALES PERSON	FIRST TIM	RECURRIN	PLAN ADD	TOTAL PAYOUT	
279147	ANAHIT	[redacted]	544880	02/02/2010	01/25/2010	01/28/2010	S01	BANK	DEBIT	$390.00	ATA5000C-$390	HEATH PARKS	$0.00	(~6.00)	$0.00	(~6.00)	43.75
277793	APRIL	[redacted]	544882	02/02/2010	01/22/2010	01/28/2010	S01	BANK	DEBIT	$195.00	ATA2500N-$195 75	ERIC HEAD	$0.00	(~6.00)	$0.00	($6.00)	38.75
277775	CAROLYN	[redacted]	544883	02/02/2010	01/22/2010	01/28/2010	S01	BANK	DEBIT	$195.00	ATA2500N-$195 75	WAYNE BULL	$0.00	(~6.00)	$0.00	($6.00)	38.75
277835	CHRISTOPHER	[redacted]	544884	02/02/2010	01/22/2010	01/28/2010	S01	BANK	DEBIT	$260.00	ATA5000S - 390	WAYNE BULL	$0.00	(~6.00)	$0.00	(~6.00)	11.75
279221	DENISE	[redacted]	544887	02/02/2010	01/26/2010	01/28/2010	S01	BANK	DEBIT	$365.00	NAT CHOICE N-$365	ERIC HEAD	$0.00	$11.54	$0.00	$11.54	11.54
277709	DIANE	[redacted]	544889	02/02/2010	01/21/2010	01/28/2010	S01	BANK	DEBIT	$185.00	PLUS500N-$185	WAYNE BULL	$0.00	($6.00)	$0.00	($6.00)	51.94
277781	EDWARD	[redacted]	544890	02/02/2010	01/22/2010	01/28/2010	S01	BANK	DEBIT	$340.00	ATA2500N-$340	WAYNE BULL	$0.00	$139.00	$0.00	$139.00	[illegible] 173.75
277787	FAITH	[redacted]	544891	02/02/2010	01/22/2010	01/28/2010	S01	BANK	DEBIT	$470.00	ATA5000F-$470	HEATH PARKS	$0.00	($6.00)	$0.00	($6.00)	75.75
277749	FRANCES	[redacted]	544892	02/02/2010	01/22/2010	01/28/2010	S01	BANK	DEBIT	$364.00	NAT CHOICE N-$364.21 125	WAYNE BULL	$0.00	$10.75	$0.00	$10.75	10.75
277719	GARY	[redacted]	544893	02/02/2010	01/21/2010	01/28/2010	S01	BANK	DEBIT	$364.00	NAT CHOICE N-$364.21 125	WAYNE BULL	$0.00	$10.75	$0.00	$10.75	10.75
279158	GINNY	[redacted]	544894	02/02/2010	01/25/2010	01/28/2010	S01	BANK	DEBIT	$185.00	PLUS500N-$185	ERIC HEAD	$0.00	($6.00)	$0.00	($6.00)	51.94
279126	JAMES	[redacted]	544896	02/02/2010	11/01/2008	01/28/2010	S01	BANK	DEBIT	$280.00	ATA2500S-$280		$0.00	($66.00)	$0.00	($66.00)	[illegible] 1.25
277785	JOSEPHINE	[redacted]	544898	02/02/2010	01/22/2010	01/28/2010	S01	BANK	DEBIT	$185.00	PLUS500N-$185	WAYNE BULL	$0.00	($6.00)	$0.00	($6.00)	51.94
279124	KAREN	[redacted]	544900	02/02/2010	11/01/2008	01/28/2010	S01	BANK	DEBIT	$440.00	ATA7500S-$440	WAYNE BULL	$0.00	($6.00)	$0.00	($6.00)	3.75
279460	LINDA	[redacted]	544902	02/02/2010	01/28/2010	01/28/2010	S01	BANK	DEBIT	$439.00	NAT CHOICE N-$364.21 75	ERIC HEAD	$55.00	$10.75	$0.00	$65.75	10.75
279462	LYNETTE	[redacted]	544904	02/02/2010	01/28/2010	01/28/2010	S01	BANK	DEBIT	$340.00	ATA2500S-$340		$0.00	$139.00	$0.00	$139.00	57.75
279214	MARK	[redacted]	544905	02/02/2010	01/26/2010	01/28/2010	S01	BANK	DEBIT	$390.00	ATA5000C-$390	WAYNE BULL	$0.00	($6.00)	$0.00	($6.00)	43.75
279110	MARK	[redacted]	544906	02/02/2010	11/01/2008	01/28/2010	S01	BANK	DEBIT	$664.00	NAT CHOICE S-$662.80 75	STEPHANIE WALTZ	$0.00	$32.55	$0.00	$32.55	30.15

277791 MATHEW [redacted]	544907 02/02/2010	01/22/2010	01/28/2010	S01	BANK	DEBIT	$185.00	PLUS500N-$185		ERIC HEAD	$0.00	($6.00)	$0.00	($6.00)	51.94
279502 MONICA [redacted]	544908 02/02/2010	01/28/2010	01/28/2010	S01	BANK	DEBIT	$440.00	ATA7500S-$440		WAYNE BULL	$0.00	($6.00)	$0.00	($6.00)	3.75
279184 NADENE [redacted]	544909 02/02/2010	01/25/2010	01/28/2010	S01	BANK	DEBIT	$915.00	NAT CHOICE FAMILY + CI			$0.00	$80.02	$0.00	$80.02	80.02
279286 NANCY [redacted]	544910 02/02/2010	01/27/2010	01/28/2010	S01	BANK	DEBIT	$364.00	NAT CHOICE N-$364.21 125		WAYNE BULL	$0.00	$10.75	$0.00	$10.75	10.75
277858 NANDINI [redacted]	544911 02/02/2010	01/22/2010	01/28/2010	S01	BANK	DEBIT	$525.00	ATA7500F-$525			$0.00	($6.00)	$0.00	($6.00)	11.75
279309 OLGA [redacted]	544912 02/02/2010	01/27/2010	01/28/2010	S01	BANK	DEBIT	$364.00	NAT CHOICE N-$364.21 75		WAYNE BULL	$0.00	$10.75	$0.00	$10.75	10.75
277687 PAUL [redacted]	544913 02/02/2010	01/21/2010	01/28/2010	S01	BANK	DEBIT	$489.00	NAT CHOICE N-$364.21 125		ERIC HEAD	$105.00	$10.75	$0.00	$115.75	10.75
279459 RACHEL [redacted]	544914 02/02/2010	01/28/2010	01/28/2010	S01	BANK	DEBIT	$195.00	ATA2500N-$195 75			$0.00	($6.00)	$0.00	($6.00)	28.75
279107 RICHARD [redacted]	544916 02/02/2010	11/01/2008	01/28/2010	S01	BANK	DEBIT	$364.00	NAT CHOICE N-$364.21 75		ERIC HEAD	$0.00	$10.75	$0.00	$10.75	10.75
277843 RICKY [redacted]	544917 02/02/2010	01/22/2010	01/28/2010	S01	BANK	DEBIT	$185.00	PLUS500N-$185		WAYNE BULL	$0.00	($6.00)	$0.00	($6.00)	51.94
277682 RONALD [redacted]	544919 02/02/2010	11/01/2008	01/28/2010	S01	BANK	DEBIT	$285.00	ATA7500N-$285		ERIC HEAD	$0.00	($6.00)	$0.00	($6.00)	43.75
277789 RONALD [redacted]	544921 02/02/2010	01/22/2010	01/28/2010	S01	BANK	DEBIT	$195.00	ATA2500N-$195 75		WAYNE BULL	$0.00	($6.00)	$0.00	($6.00)	28.75
277771 SANDY [redacted]	544922 02/02/2010	01/22/2010	01/28/2010	S01	BANK	DEBIT	$440.00	ATA7500S-$440		WAYNE BULL	$0.00	($6.00)	$0.00	($6.00)	3.75
277784 SHARON [redacted]	544923 02/02/2010	01/22/2010	01/28/2010	S01	BANK	DEBIT	$185.00	PLUS500N-$185		WAYNE BULL	$0.00	($6.00)	$0.00	($6.00)	51.94
277700 STANLEY [redacted]	544924 02/02/2010	01/21/2010	01/28/2010	S01	BANK	DEBIT	$470.00	ATA5000F-$470		HEATH PARKS	$0.00	($6.00)	$0.00	($6.00)	15.75
279445 STEVEN [redacted]	544925 02/02/2010	01/27/2010	01/28/2010	S01	BANK	DEBIT	$364.00	NAT CHOICE N-$364.21 125		WAYNE BULL	$0.00	$10.75	$0.00	$10.75	10.75
277857 THELMA [redacted]	544926 02/02/2010	01/22/2010	01/28/2010	S01	BANK	DEBIT	$195.00	ATA2500N-$195 75		HEATH PARKS	$0.00	($6.00)	$0.00	($6.00)	28.75
279127 DONALD [redacted]	545744 02/03/2010	11/01/2008	01/29/2010	S01	BANK	DEBIT	$364.00	NAT CHOICE N-$364.21 75		NO DEPARTMENT ND	$0.00	$10.75	$0.00	$10.75	10.75
279472 KIRK [redacted]	545746 02/03/2010	11/01/2008	01/29/2010	S01	BANK	DEBIT	$275.00	PLUS 500S-275		NO DEPARTMENT ND	$0.00	$75.54	$0.00	$75.54	71.68
279128 PATRICIA [redacted]	545747 02/03/2010	11/01/2008	01/29/2010	S01	BANK	DEBIT	$470.00	ATA5000F-$470		NO DEPARTMENT ND	$0.00	($6.00)	$0.00	($6.00)	15.75
279541 ROSS [redacted]	545748 02/03/2010	01/29/2010	01/29/2010	S01	BANK	DEBIT	$364.00	NAT CHOICE N-$364.21 75		HEATH PARKS	$0.00	$10.75	$0.00	$10.75	10.75

279648 PARTHENA [redacted]	547558 02/02/2010	02/01/2010	02/01/2010	S01	CARD	DEBIT	$525.00	ATA7500F-$525		HEATH PARKS	$0.00	($6.00)	$0.00	($6.00)	11.75
279108 JOYCE [redacted]	547680 02/04/2010	11/01/2008	02/01/2010	S01	BANK	DEBIT	$364.00	NAT CHOICE N-$364.21 75		ERIC HEAD	$0.00	$10.75	$0.00	$10.75	10 75
279593 SOLOMON [redacted]	547681 02/04/2010	02/01/2010	02/01/2010	S01	BANK	DEBIT	$285.00	ATA7500N-$285		HEATH PARKS	$0.00	($6.00)	$0.00	($6.00)	43.75
279710 DANIEL [redacted]	548306 02/03/2010	02/02/2010	02/02/2010	S01	CARD	DEBIT	$195.00	ATA2500N-$195 75		WAYNE BULL	$0.00	($6.00)	$0.00	($6.00)	28.75
277683 PATRICIA [redacted]	548307 02/03/2010	01/21/2010	02/02/2010	S01	CARD	DEBIT	$855.00	NAT CHOICE F-$855.01 75		HEATH PARKS	$0.00	$43.61	$0.00	$43.61	43.61
277688 CHRISTINE [redacted]	548431 02/05/2010	01/21/2010	02/02/2010	S01	BANK	DEBIT	$855.00	NAT CHOICE F-$855.01 75		WAYNE BULL	$0.00	$43.61	$0.00	$43.61	43.61
277835 CHRISTOPHE [redacted]	548432 02/05/2010	01/22/2010	02/02/2010	S01	BANK	DEBIT	$260.00	ATA5000S - 390		WAYNE BULL	$0.00	($6.00)	$0.00	($6.00)	
279154 KARA [redacted]	548434 02/05/2010	01/25/2010	02/02/2010	S01	BANK	DEBIT	$525.00	ATA7500F-$525			$0.00	($6.00)	$0.00	($6.00)	11.75
279286 NANCY [redacted]	548436 02/05/2010	01/27/2010	02/02/2010	S01	BANK	DEBIT	$364.00	NAT CHOICE N-$364.21 125		WAYNE BULL	$0.00	$10.75	$0.00	$10.75	10.75
279981 JAN [redacted]	549175 02/05/2010	02/04/2010	02/04/2010	S01	CARD	DEBIT	$364.00	NAT CHOICE N-$364.21 75			$0.00	$10.75	$0.00	$10.75	10.75
279313 RICHARD [redacted]	549176 02/05/2010	01/27/2010	02/04/2010	S01	CARD	DEBIT	$340.00	ATA2500N-$340		HEATH PARKS	$0.00	$139.00	$0.00	$139.00	~~+73.75~~ CANCEL
279313 RICHARD [redacted]	549176 02/05/2010	01/27/2010	02/04/2010	S01	CARD	DEBIT	$340.00	ATA2500S-$340		HEATH PARKS	$0.00	$139.00	$0.00	$139.00	58.75
279309 OLGA [redacted]	548707 02/03/2010	01/27/2010	02/03/2010	S01	BANK	CREDIT I	($364.00)	NAT CHOICE N-$364.21 75		WAYNE BULL	$0.00	($10.75)	$0.00	($16.75)	-16.75
279110 MARK [redacted]	548746 02/03/2010	11/01/2008	02/03/2010	S01	BANK	CREDIT I	($1.20)	NAT CHOICE S-$662.80 75		STEPHANIE WALTZ	$0.00	($32.55)	$0.00	($1.20)	-1.20
279154 KARA [redacted]	549461 02/05/2010	01/25/2010	02/05/2010	S01	BANK	CREDIT I	($525.00)	ATA7500F-$525			$0.00	$6.00	$0.00	$0.00	-11 75
279084 KATHLEEN [redacted]	548435 02/08/2010	11/01/2008	02/02/2010	R03	BANK	DEBIT	$364.00	NAT CHOICE N-$364.21 75		WAYNE BULL	$0.00	$0.00	$0.00	($6.00)	- 6
279117 PERSIA [redacted]	550306 02/11/2010	11/01/2008	02/05/2010	R03	BANK	DEBIT	$364.21	NAT CHOICE N-$364.21 75		WAYNE BULL	$0.00	$0.00	$0.00	($6.00)	- 6
277853 ROBERT [redacted]	551144 02/11/2010	01/22/2010	02/08/2010	R01	BANK	DEBIT	$275.00	PLUS 5005-275		WAYNE BULL	$0.00	$0.00	$0.00	($6.00)	- 6

Sub-Total	$878.67	1428.30
Points	($86.43)	(86.43)

ATA Payout Report: 02/22/2010

MEMBER I	FIRST NAM	LAST NAME	TRANS ID	FUND DATE	CREATED DA	BILLED DATE	BILLI	METHO	TYPE	AMT BIL	PLAN	SALES PERSON	FIRST TIM	RECURRIN	PLAN ADD	TOTAL PAYOUT	
277699	DENNIS	[redacted]	548892	02/08/2010	01/21/2010	02/03/2010	S01	BANK	DEBIT	$365.00	NAT CHOICE N-$365	WAYNE BULL	$0.00	$11.54	$0.00	$11.54	11.54
279782	DUSHYAUT	[redacted]	548893	02/08/2010	02/03/2010	02/03/2010	S01	BANK	DEBIT	$525.00	ATA7500F-$525		$0.00	($6.00)	$0.00	($6.00)	11.75
279861	GARY	[redacted]	548894	02/08/2010	02/03/2010	02/03/2010	S01	BANK	DEBIT	$365.00	NAT CHOICE N-$365	ERIC HEAD	$0.00	$11.54	$0.00	$11.54	11.54
279858	GLORIE	[redacted]	548895	02/08/2010	02/03/2010	02/03/2010	S01	BANK	DEBIT	$364.00	NAT CHOICE N-$364.21 75	HEATH PARKS	$0.00	$10.75	$0.00	$10.75	10.75
279457	JEANNE	[redacted]	548896	02/08/2010	01/28/2010	02/03/2010	S01	BANK	DEBIT	$275.00	PLUS500S - 275		$0.00	$0.00	$0.00	$0.00	32.68
279129	SAMMY	[redacted]	549283	02/09/2010	11/01/2008	02/04/2010	S01	BANK	DEBIT	$855.00	NAT CHOICE F-$855.01 125	ERIC HEAD	$0.00	$43.61	$0.00	$43.61	43.61
277835	[redacted]		550302	02/10/2010	01/22/2010	02/05/2010	S01	BANK	DEBIT	$260.00	PLUS500S - 275	WAYNE BULL	$0.00	($6.00)	$0.00	($6.00)	
277791	MATHEW	[redacted]	550303	02/10/2010	01/22/2010	02/05/2010	S01	BANK	DEBIT	$185.00	PLUS500N-$185	ERIC HEAD	$0.00	($6.00)	$0.00	($6.00)	51.94
279091	MICHAEL	[redacted]	550304	02/10/2010	01/23/2010	02/05/2010	S01	BANK	DEBIT	$557.00	ATA7500F-$557		$0.00	$26.00	$0.00	$26.00	43.75
279286	NANCY	[redacted]	550305	02/10/2010	01/27/2010	02/05/2010	S01	BANK	DEBIT	$364.21	NAT CHOICE N-$364.21 125	WAYNE BULL	$0.00	$10.75	$0.00	$10.75	10.75
279356	RICHARD	[redacted]	550307	02/10/2010	01/27/2010	02/05/2010	S01	BANK	DEBIT	$428.00	ATA5000S + CI 428	WAYNE BULL	$0.00	$111.87	$0.00	$111.87	111.87
277682	RONALD	[redacted]	550308	02/10/2010	11/01/2008	02/05/2010	S01	BANK	DEBIT	$285.00	ATA7500N-$285	ERIC HEAD	$0.00	($6.00)	$0.00	($6.00)	43.75
279782	DUSHYAUT	[redacted]	551143	02/11/2010	02/03/2010	02/08/2010	S01	BANK	DEBIT	$525.00	ATA7500F-$525		$0.00	($6.00)	$0.00	($6.00)	11.75
279991	JOANNA	[redacted]	551333	02/10/2010	02/04/2010	02/09/2010	S01	CARD	DEBIT	$364.21	NAT CHOICE N-$364.21 75	WAYNE BULL	$0.00	$10.75	$0.00	$10.75	10.75
279917	KHAIROOL	[redacted]	551334	02/10/2010	02/04/2010	02/09/2010	S01	CARD	DEBIT	$285.00	ATA7500N-$285	WAYNE BULL	$0.00	($6.00)	$0.00	($6.00)	43.75
279130	DONALD	[redacted]	551464	02/12/2010	11/01/2008	02/09/2010	S01	BANK	DEBIT	$260.00	ATA5000N-$260	ERIC HEAD	$0.00	($6.00)	$0.00	($6.00)	43.75
279125	LENNY	[redacted]	551466	02/12/2010	11/01/2008	02/09/2010	S01	BANK	DEBIT	$365.00	NAT CHOICE N-$365	NO DEPARTMENT ND	$0.00	$11.54	$0.00	$11.54	11.54
279126	JAMES	[redacted]	551467	02/12/2010	11/01/2008	02/09/2010	S01	BANK	DEBIT	$280.00	ATA2500S-$280		$0.00	($66.00)	$0.00	($66.00)	-1.25

279924 KATHRYN [redacted]	551468 02/12/2010	02/04/2010	02/09/2010	S01	BANK	DEBIT	$275.00	PLUS500S - 275			$0.00	$0.00	$0.00	$0.00	72.68
280009 JILL [redacted]	551469 02/12/2010	02/04/2010	02/09/2010	S01	BANK	DEBIT	$470.00	ATA5000F-$470		WAYNE BULL	$0.00	($6.00)	$0.00	($6.00)	15.75
280070 LINDA [redacted]	551470 02/12/2010	02/08/2010	02/09/2010	S01	BANK	DEBIT	$195.00	ATA2500N-$195 75		WAYNE BULL	$0.00	($6.00)	$0.00	($6.00)	28.75
279121 MARIA [redacted]	551471 02/12/2010	11/01/2008	02/09/2010	S01	BANK	DEBIT	$663.00	NAT CHOICE S-$663		ERIC HEAD	$0.00	$30.75	$0.00	$30.75	30.35
279131 SUSAN [redacted]	551474 02/12/2010	11/01/2008	02/09/2010	S01	BANK	DEBIT	$195.00	ATA2500N-$195 125		STEPHANIE WALTZ	$0.00	($6.00)	$0.00	($6.00)	28.75
279132 PAULINE [redacted]	551475 02/12/2010	11/01/2008	02/09/2010	S01	BANK	DEBIT	$364.21	NAT CHOICE N-$364.21 75		WAYNE BULL	$0.00	$10.75	$0.00	$10.75	10.75
279133 PATRICIA [redacted]	551476 02/12/2010	11/01/2008	02/09/2010	S01	BANK	DEBIT	$364.21	NAT CHOICE N-$364.21 75		WAYNE BULL	$0.00	$10.75	$0.00	$10.75	10.75
279844 MARK [redacted]	551478 02/12/2010	02/03/2010	02/09/2010	S01	BANK	DEBIT	$662.80	NAT CHOICE S-$662.80 75		WAYNE BULL	$0.00	$30.55	$0.00	$30.55	30.15
280454 NICK [redacted]	553291 02/12/2010	02/11/2010	02/11/2010	S01	CARD	DEBIT	$285.00	ATA7500N-$285		ERIC HEAD	$0.00	($6.00)	$0.00	($6.00)	43.75
277709 DIANE [redacted]	552367 02/10/2010	01/21/2010	02/10/2010	S01	BANK	CREDIT	($185.00)	PLUS500N-$185		WAYNE BULL	$0.00	$6.00	$0.00	($6.00)	-57.94
279123 NICHOLAS [redacted]	551473 02/16/2010	11/01/2008	02/09/2010	R04	BANK	DEBIT	$364.21	NAT CHOICE N-$364.21 75		STEPHANIE WALTZ	$0.00	$0.00	$0.00	($6.00)	[redacted] -6
279924 KATHRYN [redacted]	551468 02/16/2010	02/04/2010	02/09/2010	R03	BANK	DEBIT	$275.00	PLUS500S - 275			$0.00	$0.00	$0.00	$0.00	[redacted] -6
279599 [redacted]	552649 02/17/2010	02/01/2010	02/10/2010	R03	BANK	DEBIT	$195.00	ATA2500N-$195 75		HEATH PARKS	$0.00	$0.00	$0.00	($6.00)	[redacted] -6
280469 MICHAEL [redacted]	553436 02/18/2010	02/11/2010	02/11/2010	R01	BANK	DEBIT	$185.00	PLUS500N-$185		WAYNE BULL	$0.00	$0.00	$0.00	($6.00)	[redacted] -6
277708 JASON [redacted]	555819 02/18/2010	01/21/2010	02/17/2010	FRAUD	CARD	DEBIT	$195.00	ATA2500N-$195 75		HEATH PARKS	$0.00	$0.00	$0.00	($6.00)	-6
277708 JASON [redacted]	556839 02/19/2010	01/21/2010	02/18/2010	FRAUD	CARD	DEBIT	$195.00	ATA2500N-$195 75		HEATH PARKS	$0.00	$0.00	$0.00	($6.00)	-6

Sub-Total	$163.15	731.96
Points	($43.70)	(43.70)
Total Payout	$119.45	678.26

a Grigg
ew Dr
75070-3845

a Grigg
ew Dr
75070-3845

7001 0320 0004 2177 4923

UNITED STATES POSTAL SERVICE

1000

37172

PAID
PRINCETON, TX
75407
MAR 22, '10
AMOUNT
$6.49
00022080-04

EXHIBIT 8 to hesse

AMERICARE HEALTH
CLAIMS DEPT.
4646 HIGHWAY 41 N.
SPRINGFIELD, [redacted] TN. 37172

RETURN RECEIPT
REQUESTED

a Grigg
ew Dr
75070-3845

a Grigg
ew Dr
75070-3845

7001 0320 0004 2177 4923

UNITED STATES POSTAL SERVICE

1000

37172

PAID
PRINCETON, TX
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AMOUNT
$6.49
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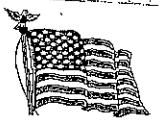
EXHIBIT 8 to hesse

AMERICARE HEALTH
CLAIMS DEPT.
4646 HIGHWAY 41 N.
SPRINGFIELD, [redacted] TN. 37172

RETURN RECEIPT
REQUESTED

IN GOD we TRUST.



MEDRECOVERY SOLUTIONS
POBOX 502
SINTON, TX 78387

CERTIFIED MAIL™

7008 3230 0000 5025 0999

UNITED STATES POSTAL SERVICE

1000

37172

U.S. POSTAGE
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SINTON, TX
78387
MAR 22, '10
AMOUNT
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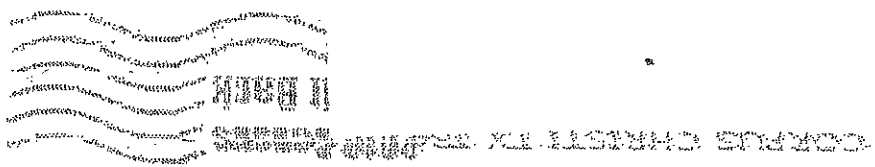
Healthcare America
46676 HWY 41 North
Springfield, TN 37172

3717285867



FEB 11 2010

Mr. Obed Kirkpatrick
Mr. Bart Posey
American Trade Association & Smart Data Solutions, LLC
4676 Highway 41 North
Springfield, TN 37172

Gentlemen:

Re: Investigation of American Trade Association Health Plans

This office is conducting an investigation of the above-referenced matter pursuant to §504(a)(1) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §1134(a)(1), to determine whether any person has violated or is about to violate any provision of Title I of ERISA. Enclosed is a subpoena which requires you to produce certain documents and records in connection with that investigation.

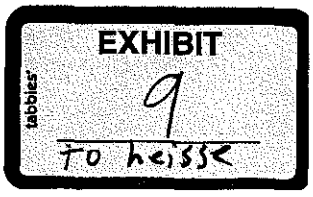
Your personal appearance pursuant to this subpoena will not be required at this time provided the documents are produced on or before the date noted in the subpoena. You will be informed at a later date if your personal appearance to testify is required. Inasmuch as your appearance is not now being required, please provide a cover letter with your response which identifies the documents being produced. Your cover letter should also state whether a diligent search has been made for the subpoenaed documents and that the documents transmitted constitute all documents called for by the subpoena.

The subpoena requests that documents maintained in electronic form, Electronically Stored Information ("ESI"), be produced in electronic form. The formats in which EBSA can accept ESI are listed in the subpoena. When producing ESI, the material should be produced as maintained on your computer system, i.e., ESI should be produced with all files, folders and sub-folders intact, and emails should be produced with all attachments intact.

In reference to document production items #37 and #40, in lieu of providing copies of all notices sent to employer-sponsored participants, please provide 10 examples of each notice.

If any documents called for are not furnished, please list such documents and indicate their location and the reason for their non-production.

This inquiry should not be construed as an indication that any violations of law have occurred or as a reflection upon any person involved in this matter.



If you have any questions concerning your rights and duties, you may wish to consult counsel. If you have any questions concerning the subpoena or the documents required to be produced, including the production of ESI and the appropriate format and media, please call Senior Investigator Michael Morrow at (404) 302-3940.

Sincerely,

2/10/10

R.C. MARSHALL
Regional Director

Enclosure

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2/9/10

SUBPOENA ARO 40-1155

UNITED STATES OF AMERICA
DEPARTMENT OF LABOR
Employee Benefits Security Administration

To: *Mr. Obed Kirkpatrick*
Mr. Bart Posey
American Trade Association & Smart Data Solutions, LLC
4676 Highway 41 North
Springfield, TN 37172

You are hereby required to appear before Senior Investigator Michael Morrow of the Employee Benefits Security Administration, U.S. Department of Labor, at 61 Forsyth Street, Suite 7B54, Atlanta, GA 30303, on the 1st day of March 2009, at 9:00 a.m. of that day, in the Matter of an investigation of the

American Trade Association Health Plans

being conducted pursuant to Section 504 of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. Section 1134, in order to determine whether any person has violated or is about to violate any provision of Title I of ERISA or any regulation or order thereunder;

And you are hereby required to bring with you and produce at said time and place the following books, papers, and documents:

See Attached

Fail not at your peril.

DEPARTMENT OF LABOR · UNITED STATES OF AMERICA ·

In testimony whereof I have hereunto affixed my signature and the seal of the United States Department of Labor

at Atlanta, Georgia .

this 10 *day of* February, *2010*

R.C. MARSHALL, Regional Director

Attachment to Subpoena

AMERICAN TRADE ASSOCIATION

I. DEFINITIONS:

A. The words "You" or "Your" shall mean Mr. Obed Kirkpatrick and Mr. Bart Posey and any predecessor or successor corporations, alias entities, divisions, affiliates or subsidiaries, as well as all present or former owners, officers, directors, partners, employees, agents, or other persons acting on its behalf or under its direction or control.

B. "American Trade Association" shall mean any alias entity, affiliate, subsidiary, division or employee of such, to also include entities which are related, or under common control or ownership.

C. "Smart Data Solutions, LLC" shall mean any alias entity, affiliate, subsidiary, division or employee of such, to also include entities which are related, or under common control or ownership.

D. The term "Plan" and/or "Plans" shall mean any ERISA-covered health or medical plan serviced by, under fiduciary control, or under directed-trustee control of American Trade Association.

E. The term "Plan" and/or "Plans" shall mean an employee benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. Section 1002(1) and sections related thereto.

F. The term "participant or participants" shall mean individuals who participate or participated in the Plan(s);

G. The term "beneficiary" shall mean a person entitled to a benefit arising from an appointment, assignment, disposition, instrument, or legal arrangement;

H. The term "document" or "documents" means, including but not limited to, all writings, recordings or electronic data consisting of letters, words, or numbers, or their equivalent, set down by handwriting, typewriting, word processing, printing, photostatting, photographing, magnetic impulse, mechanical or electronic recording, still photographs, X-ray films, video tapes, motion pictures, electronic mail messages (email), voice mail messages, electronic instant messages (IM), spreadsheets, databases, facsimile, electronic calendars and contact managers, back-up data, and or other form of data compilation, stored in any medium from which information can be obtained (including but not limited to magnetic tape, magnetic disk, CD-ROM, DVD, optical disk, flash drive or other electronic or mechanical storage device), however produced, reproduced or stored, of every kind of description within the Company's possession, custody, or control of any

agent, employee, representative or other persons acting or purporting to act for or on behalf of the Company, included but not limited to notes; memoranda; records; reports; correspondence; telexes and faxes; agreements; contracts; accounting or financial records or worksheets; account books; journals; ledgers; bills; receipts; vouchers; transcripts or notes of conversations or meetings; minutes of meetings; statements; directives in any form from general partners or other representatives; diary entries; studies; summaries and/or records of telephone conversations; interviews, meetings and/or conferences; tabulations; and shall include the original and all non-identical copies; all drafts even if not published, disseminated, or used for any purpose; all notes, schedules, footnotes, attachments, enclosures, and documents attached or referred to in any document to be produced pursuant to this subpoena.

I. The term "relate to" or "relating to" means constituting, referring to, pertaining to, responding to, regarding, evidencing, explaining, discussing, depicting, analyzing, or containing any information which in any way concerns, affects, or describes the terms or conditions, or identifies facts, with respect to the subject of the inquiry.

J. The term "communication" or "communications" means any oral, written or other exchange or transmission of information (in the form of facts, ideas, inquiries, opinions, analysis or otherwise), including correspondence, memos, reports, facsimiles, emails, electronic documents, telephone conversations, telephone or voicemail messages, face-to-face meetings or conversations, and Internet postings and discussions.

K. The term "email" or "electronic mail" means any electronic communication made using computer communications software, whether through a local computer network or through the Internet, and whether maintained in electronic form and/or paper form. Email maintained in electronic form may be produced in electronic form.

L. The terms "and" and "or," as used herein, shall be construed conjunctively or disjunctively as necessary to make the request inclusive rather than exclusive.

M. The use of the word "including" shall be construed to mean "without limitation."

II. GENERALLY APPLICABLE INSTRUCTIONS

A. Scope of search. This subpoena calls for all documents in your possession, custody, or control. You are required to search for, obtain, and produce all responsive documents, including without limitation documents that are in your custody or control, but not in your immediate possession. This includes any responsive documents in the possession, custody, or control of any person acting on your behalf or under your direction or control, such as your employees, accountants, agents, representatives, attorneys, or advisors.

B. Relevant time period. Unless otherwise specified, the time period covered by this subpoena is from January 1, 2007 to the date of production. Documents created prior to January 1, 2007 which have been used or relied on since January 1, 2007 or which describe legal duties which remain in effect after January 1, 2007 (such as contracts), shall be considered as included within the time period covered by this subpoena.

C. Privileges and Protections. If you do not produce documents because you object to part of or an aspect of a request, please provide a written response stating the precise basis for the objection and produce all documents responsive to the remaining part or aspect of the requests.

If any documents responsive to this subpoena are withheld because of a claim of privilege, identify the documents you claim are privileged in a written response, and indicate for each such document: 1) the nature of the privilege or protection claimed; 2) the factual basis for claiming the privilege or protection asserted; 3) the subject matter of the document; 4) the type, length, and date of the document; 5) the author of and/or signatory on the document; and 6) the identity of each person to whom the document was directed or distributed.

D. Electronically stored information. If any document called for by this subpoena exists as, or can be retrieved from, information stored in electronic or computerized form, then you are directed to produce the document in computerized form in one of the following formats: Microsoft Word (doc), WordPerfect (wpd), Rich Text (rtf), Microsoft Outlook (pst), Microsoft Outlook Express (msg), Microsoft Excel (xls), Microsoft Access (mdb), PDF, TIFF, CSV, ASCII, TXT, Concordance, or Quickbooks. Files of the preceding types can be submitted in a ZIP compressed format. Sufficient information including sufficient identification of the applicable software program and passwords, if any, should be provided to permit access to and use of the documents. Images created through a scanning process should have a minimum resolution of 300 dots per inch (dpi).

E. Tenses. Verbs used in the past tense should be read also to include the present tense, and verbs used in the present tense should be read also to include the present tense.

F. Singular/Plural. The singular number of a noun, pronoun, or verb should be read also to include the plural, and the plural number of a noun, pronoun, or verb should be read also to include the singular.

G. Word Neutrality. All words and phrases shall be construed as masculine, feminine or gender neutral as necessary to bring within the scope of this subpoena documents that might otherwise be construed to be outside its scope.

H. Manner of production. All documents produced in response to this subpoena shall comply with the following instructions:

a. You should conduct your searches for responsive documents in a manner sufficient to identify the source and location where each responsive document is found.

b. All documents produced in response to this subpoena shall be segregated and labeled to show the document request to which the documents are responsive and the source and location where the documents were found.

c. To the extent that documents are found in file folders and other similar containers that have labels or other identifying information, the documents shall be produced with such file folder and label information intact.

d. To the extent that documents are found attached to other documents, by means of paper clips, staples, or other means of attachment, such documents shall be produced together in their condition when found.

e. All documents provided in response to this subpoena are to include the marginalia and post-its, as well as any attachment referred to or incorporated by the documents.

f. In the event that there are no documents responsive to a particular request, please specify that you have no responsive documents.

g. If documents relied upon or required to respond to any of this subpoena, or requested documents, are no longer in your possession, custody, or control, you are required to state what disposition was made of such documents, including identification of the person(s) who are believed to be in possession or control of such documents; the date or dates on which such disposition was made, and the reason for such disposition.

h. Electronic media: To the extent that the documents that are responsive to this subpoena may exist on electronic media, those documents shall be provided on one of the following media: Compact Disk–Read Only Memory (CD-ROM), Digital Versatile Disc–Read Only Memory (DVD), or USB hard drive.

III. DOCUMENTS TO BE PRODUCED:

1. Documents that list, describe or otherwise identify all American Trade Association current and former ERISA-covered employee benefit plan clients, including, but not limited to, plan name, sponsor name and address, contact name and telephone number, employer identification number and plan number, and name(s) of plan trustee(s);

2. Documents that list, describe or otherwise identify all employer group contracts negotiated by American Trade Association and/or Smart Data Solutions, LLC with plan sponsors/employers;

3. Census Data for all employer groups participating in the BASIC, PLUS, PREMIER, ADVANTAGE, BRONZE, SILVER, GOLD, LIMITED IDEMNITY BENEFIT, PER OCCURRENCE, COMPREHENSIVE MEDICAL, ACCIDENTAL MEDICAL AND CRITICAL ILLNESS PLANS sponsored and/or serviced by American Trade Association;

4. Documents that list, describe or otherwise identify participants enrolled in any form of membership in the American Trade Association Health Plans;

5. Documents that list, describe or reflect any membership dues, fees, or payments collected from and/or received from employer-sponsored participants;

6. Documents that list, describe or reflect any membership dues, fees, or payments collected from and/or received from employer groups and/or plan sponsors;

7. All internal and external audit reports, actuarial due diligence reports, and ERISA compliance reviews;

8. All contracts and policies with employers and plan sponsors;

9. All contracts and policies with service providers providing services to the Plans that service employer groups;

10. Documents related to any lawsuits brought by American Trade Association against any party;

11. Documents related to any lawsuits and/or cease and desist orders brought against American Trade Association and/or Smart Data Solutions, LLC;

12. Documents that list, describe or otherwise identify any insurance carriers, reinsurance carriers and/or stop-loss carriers associated with the Plansoverseas;

13. All Plan trustee meeting minutes, administrator/administrative committee meeting minutes, and marketer/broker meeting minutes;

14. Records evidencing employer and employee contributions to the Plans including, but not limited to, records of Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) premiums paid by/on behalf of electing participants/beneficiaries;

15. Billing Invoices, including but not limited to documents reflecting fees charged by American Trade Association for providing services to the Plans for each plan sponsor/employer group;

16. All auto-debit, auto-draft authorizations obtained from plan sponsors/employer groups;

17. Documents that list, refer to or relate billings and receipts to corporate and personal credit cards for payment of plan premiums by plan sponsors/employer groups;

18. Documents reflecting all travel and entertainment pertaining to the Plans paid on behalf of or reimbursed to employees and agents of American Trade Association;

19. Bank statements, including cancelled checks, for all employer accounts from January 1, 2007 to the present;

20. American Trade Association Health Plan policies and procedures manuals, and any documents, which contain written policies, guidelines and procedures for the Plans;

21. Each Summary Plan Description and/or Summary of Benefits, including material modifications, used by American Trade Association;

22. All versions of the Plan Document and any trust agreement, including material modifications;

23. Adoption agreement(s), including amendments;

24. Fidelity/crime bond policy;

25. Fiduciary liability insurance policies and errors and omissions insurance policies;

26. Marketing materials, faxes, promotional and sales material, including all documents related to the solicitation of membership, including written presentations and proposals;

27. Documents that list, describe or otherwise identify the names, addresses, and telephone numbers of all individuals, brokers, and selling agents who sell, market, or solicit employers to participate in or join the Plans;

28. Documents that list, describe or otherwise identify all commissions, fees, etc., paid to sales agents, brokers, marketers or anyone for the placement of employers in the Plans;

29. All actuarial reports or studies completed and/or drafted to determine the amount of employer/participant premiums;

30. Any documents, whether internal or external, used to determine the amount of premiums and association fees to charge employers, plan sponsors and participants;

31. All documents procured during due diligence activities to determine the financial soundness of all service providers;

32. All documents procured during due diligence activities to determine the financial soundness of the Plans;

33. Forms 5500 for the years 2007, 2008 and 2009 for all employer groups;

34. All Internal Revenue Service letters of tax-exempt status;

35. Documentation of administrative expenses for the employer-sponsored Plans, including accounting, actuary, contract administration, valuation, investment, legal, trustee and other expenses paid by the Plans. Documentation must include invoices or be in sufficient detail to determine exactly what services or tasks were performed;

36. Documents sufficient to identify all corporate bank accounts owned and utilized by American Trade Association to include, but not limited to, bank address, bank name, account numbers, account name, and signatories of the accounts;

37. Documentation reflecting all states in which the Plans have employer groups and participants covered under an employer/plan sponsor arrangement;

38. Licensure from each state in which American Trade Association is licensed to sell insurance to employers/plan sponsors;

39. All certificates of creditable coverage issued to employer sponsored participants who have left the Plans, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). (In lieu of providing all notices, a list of all notices sent with 10 actual examples may be provided);

40. COBRA notices issued under the Plans;

41. Letters of determination and notification of creditable coverage issued to employer groups/participants/beneficiaries relating to any claims processed as paid or denied under the Plans (Individual Determination Letters) as required by HIPAA;

42. Notices of Preexisting Condition Exclusion provided to participants/beneficiaries since January 1, 2007;

43. Notices sent to employers, plan sponsors and participants of the Plans under the Women's Health and Cancer Rights Act;

44. Any legal opinions or correspondence related to the Plans;

45. Any documents related to the formation of a separate entity to which the Plans or American Trade Association has or will assign any rights to civil lawsuits brought by the Health Plans or American Trade Association;

46. Documents that reflect current unpaid medical claims in ERISA-covered employer arrangements;

47. Documents that list, describe or otherwise identify any claims dispute processes;

48. All communications with employers and employer-sponsored participants relating to claims payment and claims dispute;

49. All communications regarding complaints received from participants, plan sponsors and employers and responses provided;

50. Documents that list, describe or otherwise identify the names, job titles, direct-line work telephone numbers, home addresses, home telephone numbers and cellular telephone numbers of ull-time and part-time employees and/or consultants employed by American Trade Association and Smart Data Solutions, LLC;

51. Documents that list, describe or otherwise identify all facsimile numbers utilized by American Trade Association and Smart Data Solutions, LLC.

March 25, 2010

Plainview Hospital
Po Box 4324
Manhasset, NY 11030

Re: Request for Medical Records
Reference: Member ID 02023r21080
Date of Birth: 01/25/65

Dear:

The purpose of this letter is to request medical records for Michael Rainone for date of service 01/08/10. The medical records should include nurse's notes, test results, consultations with specialists and/or referrals. Your promt attention regarding this request is greatly appricated.

Sincerely,

SDS
CLAIMS DEPARTMENT
Toll Free: 800-591-6764
Fax: 800-546-7402

AFFIDAVIT OF TREY KING

STATE OF TENNESSEE)
)
COUNTY OF DAVIDSON)

I, Trey King, being duly sworn, hereby depose and aver as follows:

1. I am employed as an Investigator by the Office of Investigative Services Division of the Attorney General's Office of the State of Tennessee ("Division") and have served in that capacity for approximately 6 years. In my position with the Division, I am responsible for investigating certain matters assigned to me. I also maintain the custody of documents and other evidence for the investigations that I have been assigned. I have been employed with the State of Tennessee since 2000. Before working as an Investigator for the Division, I was a Legislative Audit Investigator for the Comptroller's Office of the State of Tennessee for 4 years. I hold a Bachelor of Science degree in Criminal Justice Administration from Middle Tennessee State University. Also, I am a Certified Fraud Examiner and a member of the Association of Certified Fraud Examiners.
2. I am currently the investigator assigned to the matter of the American Trade Association, LLC (ATA LLC), American Trade Association, Inc. ("ATA"), Smart Data Solutions, LLC ("SDS"), Bart S. Posey ("Posey") and others. All of the knowledge I have obtained about the activities of ATA LLC, ATA and SDS and the persons and entities affiliated with ATA LLC, ATA and SDS have been obtained over the course of my investigation.
3. In October 2009, I was assigned to this matter to investigate ATA LLC, ATA, SDS, and Posey for potential violations of Tennessee law. Since that time, I have interviewed

individuals involved. I have also collected and examined contracts, sales materials, the different ATA LLC and ATA websites, and other documents.

4. As of March 26, 2010, I have been conducting an investigation of activities of SDS and ATA at their offices located at 4676 Highway 41 North, Springfield, Tennessee 37172 and 400 Memorial Blvd., Springfield, Tennessee 37172.

5. During the course of my investigation, I reviewed emails that I personally printed from the computer of Bart S. Posey, who is the owner and managing member of SDS, located on the premises of SDS. From my review of Posey's desktop/office computer, it appears that he uses the email address bposey@sdsfirst.com for business related matters. Attached hereto as collective Exhibit A, is a selection of emails that I found on, and produced from, Posey's computer.

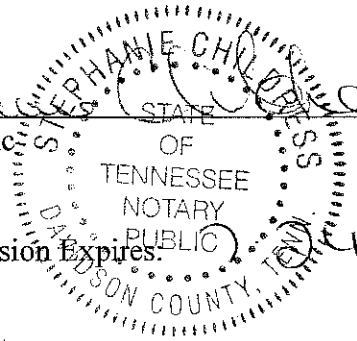
6. I also reviewed documents located in Posey's office as well as documents electronically stored on the aforementioned computer. I personally printed, and made copies of a selection of documents that were either physically located in his office, or found electronically stored on his desktop/office computer. Attached hereto as collective Exhibit B, is a selection of those documents.

FURTHER AFFIANT SAITH NOT.

Trey King

SWORN TO AND SUBSCRIBED before me on this 31st day of March, 2010.

Notary Public



My Commission Expires: 7.24.10

My Commission Expires JULY 24, 2010

Bart Posey

From: Bart Posey [bposey@sdsfirst.com]
Sent: Tuesday, April 22, 2008 10:05 AM
To: 'wworthy35@comcast.net'
Subject: RE: File

William, How can you be getting heat for not following rules,when we have not received any. Because I would have changed them to make sure we could do what we say.

Bart

-----Original Message-----
From: wworthy35@comcast.net [mailto:wworthy35@comcast.net]
Sent: Monday, April 21, 2008 9:36 PM
To: Bart Posey; Angie Posey
Subject: Fw: File

Bart,

You forgot me. Do not ask for any call or favors out of Colin. He will not be there.

Walt has filled his ear full of shit about you and Rick and I have change his mind.

The premium is due at the lastest of the 15th of the following month. This is totally unacceptable and will not be tolerated. This is the first Warning that I must give you guys to continue in the program.

I am getting a lot of heat for not following the rules.

I must have the file and the wire, NO EXCEPTION!!!!

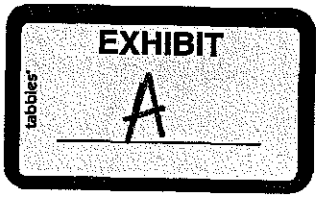
William
Sent from my Verizon Wireless BlackBerry

-----Original Message-----
From: wworthy35@comcast.net

Date: Mon, 21 Apr 2008 23:18:24
To:"Bart Posey" <bposey@sdsfirst.com>
Subject: File

Bart,

Please do not forget to get Angie to send me the file tonight and wire the money in the morning.



Thanks,

William
Sent from my Verizon Wireless BlackBerry

Bart Posey

From: wworthy35@comcast.net
Sent: Thursday, February 12, 2009 8:02 AM
To: Bart Posey
Subject: Meeting

Bart,

Just a few items:

I would give them the history of all of the other Mini Medical carrier!

Great business, profitable and boom, they term you.

Tell them that Beema came to you looking for a partner. Set up a captive for your block.

You do not sell business, but administer and "Manage" the business for Beema through the Captive.

You might want to mention that they are trying to purchase an insurance company as we speak!

With millions of people uninsured and layed off, through RBA/ATA you are providing an affordable solution for the problems that many people face.

Sent from my Verizon Wireless BlackBerry

Bart Posey

From: wworthy35@comcast.net
Sent: Tuesday, March 24, 2009 9:35 PM
To: Bart Posey
Cc: Dave Clark
Subject: Re:

Bart,

We all have spent a tremendous amount of time on our programs with Beema/Serve America and I do not think that either party is trying to mess up anything.

I am going to Ohio tomorrow to meet Dave with Paul from AFID. He, Paul, states that he has a couple of blocks to move and that he would like to revisit the High Excess Plan with the new carrier. I will keep you posted on the progress.

Currently, Beema has one association, RBA appointed, and one TPA, SDS appointed. If either party feels the need to change or broaden their opportunities then I will be glad to visit that issue. I hope that we can find a solution to move forward collectively where all parties benefit.

Sincerely,

William
----- Original Message -----
From: "Bart Posey" <bposey@sdsfirst.com>
To: wworthy35@comcast.net
Cc: "Rick Bachman" <rbachman@sdsfirst.com>
Sent: Tuesday, March 24, 2009 6:08:59 PM GMT -05:00 US/Canada Eastern

William, we have come a long way with this new plan to mess it up now. I hope that all deals that may be out there with Beema are above board and we all are aware of them. All I have asked is that we be included in all negotiation on new business. It seems we are not. Please let me know. I have a lot of time and effort in this new marketing plan,

Bart Posey
Owner/President
4676 Highway 41 North
Springfield, TN 37172
Phone; 615-382-9595
FAX: 615-382-9594

Bart Posey

From: Bart Posey [bposey@sdsfirst.com]
Sent: Friday, May 08, 2009 9:16 AM
To: 'Comcast'
Subject: FW: Beema
Attachments: ON BEEMA LETTERHEAD.doc

Bart Posey
Owner/President
4676 Highway 41 North
Springfield, TN 37172
Phone; 615-382-9595
FAX: 615-382-9594

From: Rick Bachman [mailto:rbachman@sdsfirst.com]
Sent: Friday, May 08, 2009 8:48 AM
To: 'Bart Posey'
Subject: Beema

ON BEEMA LETTERHEAD

The purpose of this document is to explain the relationship between all parties involved. Our Company, Beema Insurance Company of Pakistan owns one hundred per cent of the off-shore captive insurance company known as Serve America Assurance LLC. It was capitalized with XXXX amount of money and is domiciled in XXXXXXX. Beema Insurance Company of Pakistan has XXXXXXXXXXXX reserves and reinsures fully the liabilities of Serve America Assurance LLC. The U.S. tax ID number for Serve America Assurance is 26-4196209.

Serve America has direct contracts with the Real Benefits Association, Inc. and the America Trade Association, Inc. to provide their membership with limited benefit association based health plans. We do business directly with these two associations.

Serve America and Beema Pakistan have a contract with Smart Data Solutions, LLC based in Springfield, Tennessee to act as its administrative agent for claims processing , payment of claims and all customer service issues arising from the association membership.

Southeast Insurance Advisors based in Charleston, South Carolina is our U.S. based representative along with our U.S. based counsel being located in Columbia, So. Carolina. For further information or any further questions as to the contracts in place or the make-up of the off shore captive, Serve America Assurance please contact XXXXXXXXXX at Beema Pakistan LTD directly.

Best Regards

XXXXXXXXXX

Bart Posey

From: Comcast [wworthy35@comcast.net]
Sent: Wednesday, May 13, 2009 8:06 PM
To: Bart Posey
Subject: Re: Letter

Bart,

Did you wire the March balance of premium today?

William Worthy II

On May 13, 2009, at 10:32 AM, "Bart Posey" <bposey@sdsfirst.com> wrote:

> William, who represents Beema in the states? Once again we have side step the issue, witch leads me to believe something is not right with the way this thing is set up. If Bill was the us rep. for them he would have no problem putting this info into a letter to clear up the question.
>
> Bart Posey
>
> Owner/President
>
> 4676 Highway 41 North
>
> Springfield, TN 37172
>
> Phone; 615-382-9595
>
> FAX: 615-382-9594
>
> ---
>
> **From:** wworthy35@comcast.net [mailto:wworthy35@comcast.net]
> **Sent:** Tuesday, May 12, 2009 11:37 AM
> **To:** Bart Posey
> **Cc:** Rick Bachman
> **Subject:** Letter
>
> Bart,
>
> Please find the revised letter that will be sign and in your email in the morning.
>
> I will call to discuss.
>
> Wm

Bart Posey

From: Comcast [wworthy35@comcast.net]
Sent: Tuesday, September 08, 2009 9:22 AM
To: Bart Posey
Subject: Re: Beema

Bart,

Katie is not the contact person and you have been told this numerous times. The contact person is the underwriter on the letter sent to you and the phone number. I have been instructed by Colin Youell to have any DOI contact him.

William

On Sep 8, 2009, at 10:21 AM, "Bart Posey" <bposey@sdsfirst.com> wrote:

> William, After getting in the office this morning and reading over all the e-mails from the different states that have ask for info on Beema /SA The same issues have been avoided in each of our responses. Each state has asked who our point of contact with Beema/SA is and we have yet to answer it. SDS was told early on that Katie was to be our contact for both companies, now it looks like she dose not want her name mention to any one. We were to send all monies to Ron Ehli with ezpay and that has changed as well. With that being said that only leaves you, is it ok to give them your info? We do not have any one else to give them. If we need to give them someone to contact please give us the proper info on that person, A true phone number and address. These people are not stupid if we cannot provide a real contact person they assume that we are hiding something. What would you think. Please advise as to what to do.

Bart Posey

From: Comcast [wworthy35@comcast.net]
Sent: Wednesday, October 21, 2009 10:04 PM
To: Bart Posey
Subject: Re: Serve America

Dude, nice letter from Bill.

William

On Oct 21, 2009, at 6:33 PM, "Bart Posey" <bposey@sdsfirst.com> wrote:

<image001.gif>

October 21, 2009

Via E-Mail:

Mr. William Worthy

Southeast Insurance Advisors, LLC

Post Office Box 642

Isle of Palms, SC 29451

Re: Beema/ServeAmerica

Our File No.: 19592.30001

William:

As you know Smart Data Solutions who has been working with you based upon your representations regarding the relationship of Beema/ServeAmerica for quite some period of time now which has resulted in numerous investigations by various

departments of insurance, including but not limited to the latest and most troublesome investigation by Leslie Landwert the Oklahoma Department of Insurance.

Each and every time that SDS has been confronted with these types of investigations I've had no alternative but to refer them to my lawyer who has spent an enormous amount of time attempting to pacify the investigations, respond to the investigations and/or accommodate them, or both. On numerous occasions, including the latest occasion with Leslie Landwert, we have advised, at the direction of you, on behalf of Beema/ServeAmerica that those entities would be responding directly to the various departments regarding the premium issues, the account issues, etc. Despite our statements to that effect, no information, according to the investigators, has been received from Beema/ServeAmerica and in fact the e-mails from the Oklahoma Department of Insurance are much more pointed than that.

Specifically Oklahoma has stated in unequivocal terms that Beema has made no statements to them despite my attorney advising the various departments of insurance, based upon your statement and assurances, that a written statement is forthcoming responding to the request for information from Beema/ServeAmerica regarding insured's' payments, back accounts, etc. That, as with all other assurances has not come to fruition.

While you continue to assert that Beema Pakistan, has sent the letter, which you ultimately forwarded to us which was both factually incorrect, according to the other documentation you have been provided including the various Beema policies that we have in fact produced to various departments of insurance response to investigative subpoenas and representations you had previously made, and likewise was directly contrary to the documentation and policy what you advised us we in turn have advised the various DOIs, in reliance upon your assurances, representation and the actual policies we've been provided indicating Beema as in fact the insured as referenced in the letters directly from you. Upon being questioned about that letter (undated and unaddressed) you indicated that you were not certain if it had been sent; however, I am certain that we were never consulted regarding the contents thereof and have never seen a copy of any such letter that was actually apparently authored and/or sent to the respective DOIs although you've indicated that in fact that was a template for the letter that was to be sent. That letter specifically states:

> "BPCL has at no time issued any insurance policy to any individual or other legal entity resident in any other state/territory of the USA."

The letter goes on to state:

> "Again for the record BPCL is regulated under the laws of Pakistan. BPCC

> does not own any subsidiary, company or corporate legal entity outside Pakistan."

It is baffling to me that the letter and/or proposed letter that you referenced to be the template containing the statements that in fact are contained therein which are directly contrary to what has been represented to us regarding Beema binding coverage. It is further directly contrary to the letter from you dated 3/10/08, undated letter you provided to us, allegedly from Collin Youell, an alleged director of Beema, not to mention the numerous policies we've been provided from Beema, according to the documentation.

Despite the statements in this undated template, your letter of 3/10/08 states:

> "It is understood that the benefits of the above listed plans are 100% insured and underwritten by and for Beema Insurance Company, LTD and its offshore capital ServeAmerica."

These statements are directly contrary to the template letter you just recently provided to me.

Since that time, I have questioned you repeatedly on exact the status of ServeAmerica and/or Beema closing on a United States insurance company which you have repeatedly indicated to me was days away from transpiring. To date, I've received no documentation substantiating any of those statements.

Of late, due to the expense associated with defending these investigations, we have again called upon Beema through you as their representative to step in, respond, support or otherwise do something to clarify Beema's position in this matter and of course the latest template letter that was supposed to help is directly contrary to what we've been told, represented to various DOIs and what the documentation that we've been provided states.

Based upon the above, the fact that these investigations continue, that we received no assistance whatsoever, been provided no input of counsel on behalf of Beema and/or been reimbursed and/or indemnified or held harmless for any of the expense incurred, not to mention the irreparable harm SDS is experiencing as a result of these numerous investigations we have yet to receive any substantive help and/or documentation and in fact despite promises to the contrary we have made, to various DOIs, after being assured of participation by Beema nothing, has been sent to them and/or forwarded to them. This

again puts SDS in a very difficult situation as the normal circumstance would be that Beema would hold harmless and indemnify the TPA under the terms of the agreement especially with regard to these types of matters and would be the primary respondent on behalf of same.

Based upon advice of counsel, unless and until we receive some assurance and/or documentation of the exact relationship between Beema, ServeAmerica and/or any other captive and/or ServeAmerica or other entity I have been instructed to decline to make further payments on the above.

William, the necessity of this information is clear, the promises that have been made are clear and we still stand here literally more than a year after this relationship has been undertaken with no additional information other than your continued assurances, none of which have been documented in any regard. Unless and until we receive a response satisfactory my counsel, I have been advised to cease from making any further payments and likewise do not intend to continue to rely upon your representations when in fact none of them have come into fruition.

Lastly, this will advise that SDS demands that Beema/ServeAmerica and/or such other entities as you have alluded and referenced fully indemnify and hold harmless SDS from any and all damage, attorney's fees, fines, or otherwise resulting from the failure of the responses to be forthcoming from Beema and based upon the failure to abide by the assurances made to SDS upon which we have relied.

Sincerely,

/BP

BART POSEY

Bart Posey

From: Paul [paulmiamibeach@hotmail.com]
Sent: Tuesday, November 17, 2009 12:34 PM
To: 'Rick Bachman'
Cc: bposey@sdsfirst.com
Subject: RE: ATA
Importance: High
Attachments: Insuranceplans.docx

Press Release on the New Plan

From: Rick Bachman [mailto:rbachman@sdsfirst.com]
Sent: Thursday, November 12, 2009 5:29 PM
To: 'Paul'
Cc: bposey@sdsfirst.com
Subject: RE: ATA

Thanks and hope you feel better soon

Rick

From: Paul [mailto:paulmiamibeach@hotmail.com]
Sent: Thursday, November 12, 2009 2:21 PM
To: 'Rick Bachman'
Cc: bposey@sdsfirst.com
Subject: RE: ATA
Importance: High

Rick and Bart,

Was a pleasure meeting you too and it helped a lot learning about the plans directly Thank you for coming. I am working diligently to get the rip off reports pushed down and I'm balancing my time between the 3 sites MYATA ATA and SDS so it's going to take some time it's a lot of time and work and I please urge you to be patient it takes at least 3 months before you really start seeing the positive press and rip off starts getting pushed down, trust me from years of doing this that it works. Premier Health Care was Dirt , so many rip off reports and complaints Its squeaky clean now but imagine 162,000 pages of press when I started out there were maybe 4 pages so as you can see it takes a little time I've been doing premier now for about 6 months. I'm working more not on ATA and SDS! MyATA is clean and looks pretty good so the focus is ATA and SDS. It's just a matter of time when you see those weekly reports its consistency and a lot of networking , writing , blogging , press etc on a daily basis and it will be pushed down. I had to put a lot of strategy into how I'm doing this. I will put overtime hours into it the rest of the week and the weekend and work directly on that, The one thing I need you guys to have with this is Patience and faith in my skills and work. It takes time to get 162,000 good press articles with keywords to push rip off reports down but I have done it numerous times already just stick with me and keep looking at my reports and you should see some progress over the next few weeks going into December and we will get on the phone and talk about it in detail end of the month. Moving forward from December I'm positive that I should have enough press out there that by The end of January you'll have to search to find a rip off report and be lucky if you find one. I'm home with the flu today sucks being sick. Well it was nice to hear from you and rest assured I'm on getting those pushed down as

requested and will do whatever I can do to speed up the request for you gentleman. Pleasure speaking with you and I hope your enjoying your day, Please either of you if you have a question or need an explanation of anything I am doing or would like to schedule a call please just call me it's my job to teach you guys what I'm doing and explain everything to you. Since I picked up your account , I have not taken on any new clients so I'm dedicating my time your websites and company to get you guys looking reputable getting rid of the negative press.

Best Regards,
Paul Christoforo
305-303-5584

From: Rick Bachman [mailto:rbachman@sdsfirst.com]
Sent: Thursday, November 12, 2009 10:51 AM
To: 'Paul'
Cc: 'Bart Posey'; rwaltz@sdsfirst.com
Subject: ATA

Paul

It was good to meet you this week. Hope that it helped learning more about the plans directly. Bart and Richard called me this morning about derogatory material that is new on the web about ATA. Seems several new rip off reports were filed in the last couple weeks and we have had several calls regarding them. I know you are working on pushing the MyATA to ATA directly but they both asked that whatever you can do to push it to get those issues pushed down the file it would be most appreciated.

Call me if you have any questions.

Rick

Bart Posey

From: dale@df12.com
Sent: Monday, March 01, 2010 12:29 PM
To: posey bart
Subject: ATA situation

Bart:

I just got off the phone with Dan. He said the Jared is going to pull the RE offer today at 5pm. Dan urged them to hold a day because of not being able to reach and discuss the possibilities with TN until after 1pm. I am sure you will get a letter regarding this since Jared was told that we would be back to him this morning.

Let me lay out the terrain for ATA with the way things stand. We have to make some moves here quickly or we will lose the RE and then we can all forget about even finding a front, because there is not a front that will take the business without 30-60 days of underwriting.

The Andone deal is a mess. That is understood. While I do not fully agree that it is worse than being with WW/Beema, it has been a black eye that you did not need. I am positive that Don and Gary are not going to take ATA's money, even though I have not been able to get an answer from them on what is fully going on. They have the authority to write business. I have seen the authority letter from Andone. They let us know that they could write USA business and agreed to do so on an interim basis on all states outside of the CandDs. I have a copy of the binder from Jared/Summit in which they had RE coverage direct to Andone on the ATA business. PRU could not write directly to ATA since it was a USA domiciled business. But they were on the hook for January 1 effective business and are now about to go hard ball on getting the January premium from Andone. Choi/Ketchum sent in the binder fee but did not send the premium in. This is now what has gotten Jared/Summit sideways on this deal. The reason I think they have gone under a rock is because they got so much heat from the states on Andone for taking the ATA risk, they went running over to put the money into the new RE company, First Risk, which they set up in Bermuda, and would do the coverage through that company, which they would own outright without Ed and Marty getting phone calls from the states. The calls then would come straight to them and they could battle from there as an owner instead of as a *soon-to-be-owner*.
Pelican Underwriters had let C/K know that they would do the required letters of credit for Andone or First Risk. But now they put all of the money into getting the company set up and they are stuck with no LCs to get off the ground. I know they have called Dan to ask for an insurance guarantee on a loan that would get them off the ground and to pay back ATA. Dan cannot get the guarantees without them putting up money and as he told you, he has told him, that he has no interest in helping Don T or FR if they do not bring AMLI to the table for ATA. My gut tells me that you will get the money back when they finalize their lender. They have a big block of MedMal to write, so I know they will eventually get the funds they need to finish setup and get the ATA money back. Again, Bart, this is just my gut feeing, they have not told me anything, except they are going to get back to you and us. That is it for Andone from my perspective.

For confirmation of the Andone coverage to the people that think that was not true, just package your binder, the letter of authority and the PRU binder and allow the parties to see for themselves. You can also show the states the wire transaction. This is more than enough to confirm your efforts were made and representation of Andone by ATA was by consent.

Where we are currently. I find it hard to believe that any state would rather you be naked than at least have a RE carrier that is backing you until the front can be secured. I am going to lay this out simply, if we do not have the RE in place, there will be no front that we can bring to the table. If Jared walks, we will be over as a way to help, period and he is going to walk if we throw this one out of bounds. The only reason, I got jumping on the RE first is when you called me after getting off the plane on Wednesday, you told me to at least get the RE in place and then we can worry about the front. You thought it would suffice for a couple of states (and I still believe it will) and would keep your vendors on board. I put the hard push on Dan to get the ball rolling and he in turn put the blitz on Summit to do this for us. I want you to know that Dan worked on getting this approved most of Thursday and all of Friday. Summit usually gets a large fee for just for even writing a letter like that, because it could come back to bite them if they do not produce. Jared did get one of his companies to agree. He normally would not need that, but because of the ATA battles, he just double checked to make sure. I know there is no guarantee on the front at this time. But if Jared says he can bring one, we think he can. Don T may pull a rabbit out of the hat. Dan called as I was in the middle of this letter and he has called an intermediary that has a TX company in which Dan helped put some surplus

into about 2 years ago. Ball is rolling on that. I have put in a call to Chris Peck in Atlanta. He UW/actuaries for 5-8 L&H companies. All said, everybody thinks a front will show up after the RE has taken the first bullets on the state inquiries. Jared, Dan and Chris will do letters stating their assignment as an agent to locate a front for ATA. But, since we pulled the trigger on Jared/Summit last week, if we back down, it is over.

I know that your second group of attorneys want to see a front. It makes their job easier and cleaner. Also, (since they want to lump Summit into the same ring with Andone), their meter continues to tick the longer you go without a front. Summit is not Andone. I realize the reluctance, but you are going to have to decide. Again, it does not make sense to me that any state would not want to take an acceptable RE company rather than leave everybody out there naked. The regulators will understand that with a large RE company, it will attract the front. Obviously, I am talking about the TN, IN, and TXs of the world, not OK or WA.

Finally, Dan did not bring Andone. He is getting penalized from both sides, your attorneys and Jared. Your attys are throwing Dan (and Summit) in with Andone and Jared is throwing Dan in with Andone, which is not the case at all. He is about to pull his hair out, because he is being blamed for things that he had absolutely nothing to do with on a performance/non-performance basis.

Please share this with Bill and decide what you want to do. We are still working on fronts unless you tell us to pull the plug.

Dale

REAL INSURANCE

412 - 427, Muhammadi House,I. I. Chundrigar Road, P.O. Box 5626, Karachi - 74000 Pakistan
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email: info@beemapakistan.com - beemapakistan@yahoo.com
web: www.beemapakistan.com

بیمہ پاکستان
BEEMA-PAKISTAN
COMPANY LIMITED

Mr. William M. Worthy
SouthEast Insurance Advisors, LLC.
P. O. Box 462
Isle of Palms, S.C. 29451

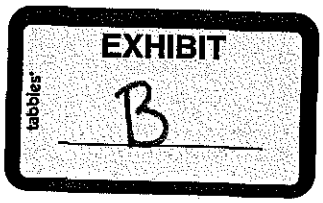
Re: Relationship-Beema-Pakistan Company, Ltd. & SouthEast Insurance Advisors, LLC.

Dear William,

This letter will serve to confirm the relationship between Beema - Pakistan Company, LTD. and your firm as our exclusive manager for our Medical Products in the United States. You will act on our behalf to negotiate terms and conditions of agreements with selected vendors. You will also assist in setting up marketing arrangements for the medical products and services underwritten by Beema-Pakistan Company, LTD. in the United States.

It is further understood that all collected premiums received by our designated TPA, Smart Data Solutions, LLC., Springfield, TN will be deposited with Mr. Ron Ehli, President, EZPay Financial Services, Inc. P.O. Box 1623, Chehalis, Wa 98532 as the Trust Manager for the Beema Accounts, at the West Coast Bank, 290 N.W. Chehalis Ave. , Chehalis, WA 98532

This letter will serve as confirmation to any interested party of the Beema-Pakistan Company, ltd. of our business relationship established January 1, 2008.



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web: www.beemapakistan.com

بیمہ پاکستان
BEEMA-PAKISTAN
COMPANY LIMITED

Sincerely,

Colin J. Youell
Director
Beema-Pakistan Company, Ltd.

Colin Youell
Director

SouthEast Insurance Advisors, LLC
Post Office Box 462
Isle of Palms, South Carolina 29451

3-10-2008

Mr. Bart Posey
Smart Data Solutions, LLC
4676 Highway 41 North
Springfield, TN 37172

Re: Mini-Med Plans, Per Occurrence Plans and Cat Plan

Dear Bart:

As per the approval from Beema Insurance Co. LTD and Serve America Assurance And under my authority as the United States Representative for the above entities, your firm is appointed as the approved Third Party Administrator for these plans effective 1-1-08. SDS, LLC agrees to maintain proper licensing and E&O Coverage for its officers and employees as part of this agreement.

You are authorized to bill and collect premium and remit net insurance premium to our trustee, Ron Ehli, of EZ-Pay Financial Services. You are authorized to pay claims for the mini-med plans, the high excess Cat plans, the per occurrence plans and the accident/medical plan. Twice monthly you will forward a list of claims to be paid along with the dollar amount of the benefits. The funds will be wired directly to your claims account by our trustee and you will release the checks upon receipt of funds.

This agreement will be for a term of 2 years from the above date and shall automatically renew in two year increments unless cancelled in writing by either

party. Either party may cancel the agreement for cause in writing with a minimum 60 day termination date. SDS, LLC agrees to open disclosure of its books regarding these plans to Beema Insurance Company LTD or its legal representative at any time with proper notice. Beema Insurance Co LTD agrees to meet any call for claims cash when proper documentation is sent to substantiate claims being due and payable. It is understood that the benefits of the above listed plans are 100% insured and underwritten by and for Beema Insurance Co. LTD and its off-shore captive Serve America Assurance.

Best Regards,

William Worthy
SouthEast Insurance Advisors LTD

REAL INSURANCE

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بیمہ پاکستان
BEEMA-PAKISTAN
COMPANY LIMITED

Tuesday, March 18, 2008

The Directors of SouthEast Insurance Advisors LLC
Via Email address

RE AUTHORIZATION TO BIND/COLLECT PREMIUM FOR THE AFFINITY MINI MED PLANS 100-1000

Dear William

We thank you, for the presentation and opportunity, to provide coverage under any of the club Mini Medical plans 100 to 1000.
You are now hereby authorized to attach coverage to us, this authority, extends to allow you, to Bind and collect premium as per the rates quoted in the documents submitted to us.

We backdate this facility to the first of Feb 2008 subject to no known or reported losses.

We do require you to set up separate bank accounts forth-with.

We shall write to you further setting out matters of a procedural nature that we need to have you adhere to.

We look forward to your confirmation we are now to proceed, in which case we will prepare out cover note setting out the terms and conditions agreed between us.

Best and kind regards

Director

REAL INSURANCE

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بیمہ پاکستان
BEEMA-PAKISTAN
COMPANY LIMITED

Tuesday, March 18, 2008

The Directors of SouthEast Insurance Advisors LLC
Via Email address

Dear William

Please be advised, following your request we Beema agree to the full assignment of the Affinity Group Benefit association Inc. To that of American Trade Association LLC. The policies include High excess Major Medical Plan, the Mini Medical Plan, The Accident Medical Plan.

Best and kind regards

Director

REAL INSURANCE

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بیمہ پاکستان
BEEMA-PAKISTAN
COMPANY LIMITED

Tuesday, March 18, 2008

The Directors of SouthEast Insurance Advisors LLC
Via Email address

Dear William

This letter will confirm that Smart Data Solutions, LLC. will serve as our Third Party Administrator for all Beema products and has the authority to collect premiums and adjudicate claims.

Many thanks,.

Director

American Trade Association

3-19-08

Mr. Dave Clark
President
Real Benefit Association Inc

Sent via e-mail

Dear Mr. Clark:

As per our conversation we would like to become part of the RBA through a bridge agreement allowing us to market the products of the RBA to our membership. It is our understanding that you have created a new class of members for the RBA to allow the sale of limited medical products and other services. We are willing to pay RBA $2.00 per month retroactive back to 2-1-08 for the mini medical plan members pepm currently enrolled through the ATA. These plans are referred to in the market as Basic 100, Value 300, Plus 500 and the Premier 1000. In addition we agree to pay $2.00 a month pepm for new members joining the ATA and purchasing these benefits going forward and $3.00 pepm for members purchasing the per occurrence plans known in the market as the 1500 plan, 2500 plan, 3500 plan, 5000 plan and the 7500 plan. These plans also include an accident medical plan with a $1,000 deductible and up to a $25,000 per occurrence benefit. In addition we will offer the high excess plan to new members with a $10,000, $20,000 or $30,000 deductible plan. There will not be any further compensation to RBA for these high excess plans. This class of members must be able to join the Association and take advantage of the health plan benefits immediately and not be required to be a member for a month prior to accessing the benefits of the association.

We would like to cap the monthly dues expense at $25,000 to RBA. Once this level has been reached ATA will continue to pay to RBA a monthly dues amount of $25,000 unless ATA total membership falls below this level. In that circumstance ATA will pay actual amount due based on the above rates of $2.00 for the mini med and $3.00 pepm for the per occurrence plans.

In exchange for these dues RBA agrees to indemnify SDS and ATA for any statutory and state compliance issues or other DOI and compliance issues as they may arise in the future. All of ATA's marketers will have purchased the E&O coverage offered by Beema through its London broker.

Additionally it is our understanding that all master contracts for the mini med plans, the per occurrence plans, the accident medical plan and the high excess plan will be issued directly to the RBA from Beema/Serve America Assurance. It is further understood and agreed that all new business written by all parties including the RBA marketers, any other association marketers affiliated with the RBA or any other groups or organizations affiliated with the RBA will be administered through Smart Data Solutions, LLC. Administration will include one- time fulfillment fee at a rate of $10.00 per member. The RBA may

either bill and collect for its members and remit eligibility monthly plus net dues to SDS, LLC, or they may elect to have SDS, LLC bill and collect at a fee to be determined.
All rates, services, marketing material or plan requests including new plan designs or changes must be submitted and approved by SDS, LLC prior to their use in the field. SDS, LLC will have contracts with the various vendors supplying services and benefits for the plans, including Beechstreet PPO, Care Continuum, Express Scripts, Member Health RX, Medsave RX, Outlook Vision, Dentemax and others as required.

We would like to move forward very quickly and can send eligibility and funds for the February and March fees immediately once the bridge agreement is sent and signed. We look forward to a long and prosperous relationship.

Best Regards,

Bart Posey
President

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بیمہ پاکستان
BEEMA-PAKISTAN
COMPANY LIMITED

Dated 12th May 12, 2009

To Whom It May Concern

Please be informed Serve America Assurance Ltd is a wholly-owned, off-shore protective cell rent a captive insurance company of Beema-Pakistan Company Limited. Serve America Assurance, Ltd is exclusively leased to Real Benefits Association, Inc. and America Trade Association, Inc. and their membership for limited benefit association-based health plans.

Serve America Assurance Ltd has a contract with Smart Data Solutions, LLC based in Springfield, Tennessee to act as their administrative agent for claims processing, claims payment and all customer service issues arising from the association membership.

Should you have additional questions or require anything further, please contact me directly.

Yours truly,

Saifuddin Ahmed
Chief Underwriter

Andone Insurance Company LTD

Windsor Place
P.O. Box 2078
Hamilton HM HX
Bermuda

January 21, 2010

CERTIFIED RETURN RECEIPT REQUEST

Bart Posey
Rich Bachman
American Trade Association
4676 Highway 41 North
Springfield, TN 37172

Re: Unauthorized use of Andone and Prudential

Dear Messrs. Posey and Bachman:

By this letter you are directed to remove immediately any mention of Andone Insurance Company LTD ("Andone") or Prudential plc ("Prudential") in any website, marketing material, advertisement, discussions (whether written or oral) through any media.

This action must be accomplished immediately. Neither you nor any organization you are associated with, directly or indirectly, is authorized to use Andone's or Prudential's name in any manner.

Please notify in writing any person who may have seen the name of Andone or Prudential or both on the website, marketing material, advertisement or who may have been a party to a written or oral communication where the name of Andone or Prudential or both was or may have been used by you or any of your associates, acquaintances, employees or agents.

Any further activity associated with marketing presentations that provides false or misleading information, as determined in our sole discretion, will initiate immediate recourse to effect appropriate market presentations.

Sincerely,

Gary L. Ketchum
[Title]

GLK Professional Services
87 Stephens State Park Road
Hackettstown, NJ 07840
For Avdon Osvorame Co Ltd.

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Mr. Bart Posey / Mr Rick Backmon
American Trade Association
4676 Highway 41 North
Springfield, TN 37172

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