



Ursa Farmers Cooperative Co. Everyday Solutions Supplemental Benefit Plan for Patron Members

Dear Patron Member,

Ursa Farmers Cooperative Co. ("UFC") has worked with local insurance representatives to offer a supplemental benefit plan to its Patron Members to help address out-of-pocket expenses when an insured or their covered loved one has injuries, illnesses, pregnancies, and more. Specifically, UFC has worked with Ware Group and APL to provide this insurance policy to Patron Members. UFC offers its Patron Members assistance collecting premiums to facilitate the special group rates and features found in the plan. Please address all questions towards your Ware Group representative as indicated below.

This benefit plan is voluntary, which means there is no obligation for a Patron Member to enroll. To help gauge interest in participation it would be appreciated if each Patron Member would let UFC know its intention by returning the Enrollment Form via the return envelope with postage paid or by any of the other methods listed on the Enrollment Form. The enrollment period is August 1<sup>st</sup> through September 30<sup>th</sup>, and the Enrollment Form must be returned during that time.

During open enrollment you will have an opportunity to attend in person, conference call, and web-based meetings which will be held during the month of August. Once a week a friendly reminder text or email will be sent to you with helpful links to learn more about this benefit. Those who have either turned in their form or those who have replied to the text or email requesting to opt out will no longer receive messages. The week prior to open enrollment ending anyone who has not turned in their form or opted out will receive an audio blast as a reminder that open enrollment ends soon.

This plan has been designed to pay in addition to any other insurance benefits you receive whether that be: health, disability, workers compensation, etc... This plan is not appropriate for anyone currently covered by Medicaid. Benefits received may be used towards deductibles, out of pocket maximums, copays, everyday living expenses, childcare, traveling expenses, etc. Patron Member is encouraged to discuss this offering with their respective benefits administrator.

You may participate in this benefit if you are a Patron Member of UFC. You may apply coverage on yourself, lawful spouse, civil union partner, dependent children, and children of a civil union partner.

Payment for this benefit will be invoiced directly by UFC to the Patron Member. The invoice for payment will be sent in October and must be paid in a full by the due date before the January 1<sup>st</sup> effective date when coverage is to begin.

Questions about the plan please contact your Ware Group representative listed below:  
Matt Rednour: 563-265-0122 or [Matt@waregroupga.com](mailto:Matt@waregroupga.com)

To review a video to learn more about this benefit please either go to the following URL or scan QR code at the top of the form: <http://bit.ly/ursasupplementaleducationvideo> to print more consumer brochures, enrollment forms, and APL acknowledgement forms please go to the following URL: <http://bit.ly/ursasupplementalforms>

# Everyday Solutions from APL

Hospital Indemnity Insurance with Accident and Critical Illness Benefits—All in One



Accident, Critical Illness and Hospital Indemnity insurance plans may help provide peace of mind and important benefits when you need them most.

Our Everyday Solutions plans include critical illness, accident and hospital indemnity benefits for **one easy decision with the same competitive rates** that fit into your everyday life.

## What's Your Plan?

Simply choose the plan that best matches your way of life and get more financial protection where you need it most.

### Critical Illness Focused Protecting Your Financial Future



26% of Americans say they have put off or postponed getting health care they needed due to costs in the past year.<sup>1</sup>

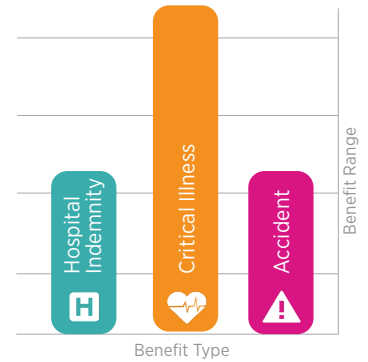
Approx. every 39 seconds an American will have a heart attack.<sup>2</sup>



#### If Your Way of Life Needs

Benefits that focus on the expenses of a critical illness such as cancer, stroke and heart attack.

Your Everyday Solution is Critical Illness Focused Plan



### Accident Focused Preparing for Unexpected Costs



Every second, a person suffers an injury requiring medical attention.<sup>3</sup>

\$72

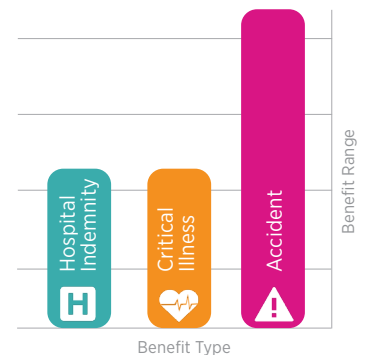
The expected cost of an arm xray.<sup>4</sup>



#### If Your Way of Life Needs

Benefits that focus on the unexpected costs of treating covered accidents.

Your Everyday Solution is Accident Focused Plan



#### THESE POLICIES PROVIDE LIMITED BENEFITS.

<sup>1</sup> Kaiser Family Foundation: Americans' Challenges with Health Care Costs; June 11, 2019



<sup>2</sup> AHA 2021 Heart Disease and Stroke Statistics Update Fact Sheet At-a-Glance; January 26, 2021, p2

<sup>3</sup> National Safety Council: Injury Facts; 2021 Web

<sup>4</sup> Healthcare Bluebook: X-Ray-Arm; Accessed from www.healthcarebluebook.com on January 16, 2020



## Summary of Benefits per Plan (Voluntary)

	 Critical Illness Focused	 Accident Focused
<b>Pregnancy Waiting Period: 0 Months</b>		
<b>Hospital Admission Benefit</b>	\$1,500 per day; maximum of 1 day	\$1,000 per day; maximum of 1 day
<b>Hospital Confinement Benefit</b>	\$150 per day; maximum of 10 days	\$100 per day; maximum of 10 days
<b>Intensive Care Unit Benefit</b>	\$200 per day; maximum of 10 days	\$100 per day; maximum of 10 days
<b>Rehabilitation Benefit</b>	\$200 per day; maximum of 5 days	\$200 per day; maximum of 5 days
<b>Accident &amp; Sickness Surgery Benefit</b>		
Surgery in a Hospital, Hospital Outpatient Facility or Freestanding Outpatient Surgery Center	\$500 per day; maximum of 1 day	\$1,500 per day; maximum of 1 day
Surgery in a Physician's Office	\$375 per day; maximum of 1 day	\$750 per day; maximum of 1 day
<b>Outpatient Accident &amp; Sickness Treatment Benefit</b>		
Emergency Room	\$500 per day; maximum of 1 day	\$1,000 per day; maximum of 1 day
Urgent Care Facility	\$100 per day; maximum of 1 day	\$100 per day; maximum of 1 day
Physician's Office	\$100 per day; maximum of 1 day	\$100 per day; maximum of 1 day
Physical, Speech or Occupational Therapy Facility	\$60 per day; maximum of 1 day	\$60 per day; maximum of 1 day
<b>Routine Health Screening Benefit</b>		
<b>Routine Health Screening Waiting Period: 0 Months</b>		
Tier 1	\$50 per day; maximum of 1 day	\$50 per day; maximum of 1 day
Tier 2	\$25 per day; maximum of 1 day	\$25 per day; maximum of 1 day
Tier 3	\$25 per day; maximum of 1 day	\$25 per day; maximum of 1 day
<b>Diagnostic Testing Benefit</b>		
Medical Imaging Tests	\$100 per day; maximum of 1 day	\$100 per day; maximum of 1 day
Advanced Study/Follow-up Tests	\$25 per day; maximum of 1 day	\$25 per day; maximum of 1 day
<b>Ambulance Benefit</b>		
Ground	\$400 per day; maximum of 1 day	\$400 per day; maximum of 1 day
Air	\$1,200 per day; maximum of 1 day	\$1,200 per day; maximum of 1 day
<b>Benefit Rider</b>		
<b>Critical Illness Rider</b>	<b>Benefit</b>	<b>Benefit</b>
Individual	\$20,000	\$10,000
Spouse**	\$20,000	\$10,000
Child(ren)***	\$10,000	\$5,000
	Benefit amount payable is 100% for invasive cancer, heart attack, permanent damage due to a stroke, major organ failure or end stage renal failure; 25% for carcinoma in situ.	Benefit amount payable is 100% for invasive cancer, heart attack, permanent damage due to a stroke, major organ failure or end stage renal failure; 25% for carcinoma in situ.
<b>Additional Rider(s)</b>		
<b>Portability Rider</b>	Included	Included

## Premiums\*

Choose between two plans for the same competitive rates.

### Monthly Premiums

	Individual	Individual & Spouse	Individual & Child(ren)	Individual & Family
Ages 18+	<b>\$66.92</b>	<b>\$134.09</b>	<b>\$78.91</b>	<b>\$158.67</b>

### Annual Premiums

	Individual	Individual & Spouse	Individual & Child(ren)	Individual & Family
Ages 18+	<b>\$803.04</b>	<b>\$1,609.08</b>	<b>\$946.92</b>	<b>\$1,904.04</b>

\*Total premium includes the Plan selected and any applicable rider premium. Premiums are subject to increase with notice.

The premium and amount of benefits vary dependent upon the Plan selected at time of application.

\*\*Spouse benefit is only applicable when Individual & Spouse or Individual & Family coverage is selected.

\*\*\* Child(ren) benefit is only applicable when Individual & Child(ren) or Individual & Family coverage is selected.

## Benefits

Benefits are per day, up to the maximum number of days per calendar year, per covered person with the exception of the Critical Illness Rider benefit. The Critical Illness Rider benefit is payable once per covered person, per calendar year. A covered person is a person who is eligible for coverage under the policy and for whom coverage is in force. Eligible dependents include your lawful spouse (spouse includes your Civil Union partner whenever referenced here in.) and/or your child (natural, adopted or step or child of your Civil Union partner) who is under 26 years of age; or a child under the age of 30 who is an Illinois resident and has served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States and has received a release or discharge other than a dishonorable discharge and who is covered under the other medical plan. We will treat a party to a civil union and a spouse in a marriage equally in our policies that are governed by your state. Any policies providing coverage for children will extend eligibility for coverage to children of Civil Unions. Benefit amounts may vary based upon place of service. Benefits will only be paid for a covered loss incurred while covered under the certificate.

**Hospital Admission Benefit** - Pays a benefit when a covered person is admitted and confined as an inpatient in a hospital due to an injury or covered sickness. APL will not pay this benefit for outpatient treatment, emergency room treatment or a stay less than 18 hours in an observation unit. This benefit is only payable once per period of confinement. A hospital is not an institution, or part thereof, used as a place for rehabilitation, a place for rest or for the aged, a nursing or convalescent home, a long-term nursing unit or geriatrics ward or an extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

**Hospital Confinement Benefit** - Pays a per day benefit when a covered person is confined as an inpatient to a hospital due to an injury or covered sickness.

**Intensive Care Unit Benefit** - Pays a per day benefit when a covered person is confined in an ICU due to an injury or covered sickness. Benefits will be paid beginning the first day of ICU confinement when the ICU confinement begins after the covered person's effective date.

**Rehabilitation Benefit** - Pays a per day benefit when a covered person is receiving rehabilitation care services while confined in a rehabilitation unit or skilled nursing facility immediately after a covered period of confinement due to an injury or covered sickness. This benefit is not payable in addition to any other confinement benefit provided under the policy on the same day. If more than one confinement occurs on the same day, the higher benefit will be paid.

**Accident & Sickness Surgery Benefit** - Pays the applicable per day benefit when a surgical procedure is performed on a covered person in a hospital, hospital outpatient facility, a freestanding outpatient surgery center or a physician's office due to an injury or covered sickness.

**Outpatient Accident & Sickness Treatment Benefit** - Pays the applicable per day benefit when a covered person receives treatment in an emergency room, urgent care facility, physician's office or physical/speech/occupational therapy facility due to an injury or covered sickness.

**Routine Health Screening Benefit - Tier 1:** Pays the applicable per day benefit when a covered person receives an annual physical. For the purpose of this benefit, this means the physician's fee only. **Tier 2:** Pays the applicable per day benefit when a covered person receives one of the following routine examinations and preventive tests under the recommendation of a physician: blood test for triglycerides, CA 15-3 (blood test for cancer), CA 19-9 (blood test for pancreatic cancer), CA 125 (blood test for ovarian cancer), CEA (blood test for colon cancer), chest x-ray, fasting blood glucose test, hemocult stool analysis, pap smear (including ThinPrep pap test), PSA (blood test for prostate cancer), routine skin check for cancer, serum cholesterol test to determine level of HDL and LDL or serum protein electrophoresis (blood test for myeloma). **Tier 3:** Pays the applicable per day benefit when a covered person receives one of the following routine examinations and preventive tests under the recommendation of a physician: breast thermography, breast ultrasound, colonoscopy, doppler ultrasound, echocardiogram, EKG (electrocardiogram), exercise or pharmacologic stress test, flexible sigmoidoscopy, mammogram, testicular ultrasound or thermography.

**Diagnostic Testing Benefit** - Pays the applicable per day benefit when a covered person receives one of the diagnostic tests listed below under the recommendation of a physician. **Medical Imaging Tests:** Magnetic Resonance Imaging (MRI), Computerized Tomography (CT) Scan, Computerized Axial Tomography (CAT) Scan, Positron Emission Tomography (PET) Scan or Radioactive Iodine (Thyroid) Uptake (RAIU) Test.

**Advanced Study/Follow-up Tests:** Angiogram, arteriogram, barium enema/lower GI series, barium swallow/upper GI series, myelogram, sleep study, nuclear stress test or transesophageal echocardiogram (TEE).

**Ambulance Benefit** - Pays a per day benefit when a covered person is transported by air or ground ambulance to a hospital or from one medical facility to another where the covered person is admitted as an inpatient and hospital confined. A licensed ambulance company must provide the ambulance service. If air and ground ambulance service are both required in the same day, the higher benefit will be paid.

## Exclusions

No benefits are payable for any loss resulting from or caused, directly by: any type of hernia, adenoids, tonsils, varicose veins, appendix, disorder of the reproduction organs within six months after the certificate effective date unless due to an emergency; war or any act of war, whether declared or undeclared, or any act related to war while serving in the military forces or any auxiliary unit thereto (We will refund the pro-rata portion of any premium paid for any such covered person upon receipt of your written request.); dental treatment or routine vision services unless due to injury and if performed within 12 months of the date of the covered accident or due to congenital defect or birth anomaly of a covered newborn child; an intentionally self-inflicted injury or sickness; committing, or attempting to commit, an illegal occupation that is defined as a felony (felony is as defined by the law of the jurisdiction in which the act takes place); an injury or sickness incurred while engaging in an illegal occupation; cosmetic care, except when the hospital confinement is due to medically necessary reconstructive plastic surgery (medically necessary reconstructive plastic surgery is defined as: surgery to restore a normal bodily function, surgery to improve functional impairment by anatomic alteration made necessary as a result of a congenital birth defect or birth anomaly, breast reconstruction following mastectomy); being intoxicated or under the influence of any narcotic unless administered by a physician or taken according to the physician's instructions (intoxication means that which is determined and defined by the laws and jurisdiction of the geographical area in which the loss or cause of loss was incurred); experimental treatment, drugs or surgery (except for those treatments, drugs or surgeries defined under Section 3); immunizations; artificial insemination, in vitro fertilization, test tube fertilization, sterilization, tubal ligation or vasectomy, and reversal thereof; participation in any sport for pay or profit; mental and emotional disorders without demonstrable organic disease, drug addiction treatment; services for which payment is not legally required, except for: Medicaid; treatment of non-service connected disabilities in Veterans Administration hospitals and care rendered to armed services retirees and dependents in military medical facilities of the United States Government; voluntary abortion except, with respect to you or your covered eligible dependent spouse: where you or your dependent spouse's life would be endangered if the fetus were carried to term

# Everyday Solutions

or where medical complications have arisen from abortion; participation in a contest of speed in power driven vehicles, parachuting or hang gliding; air travel except as a fare-paying passenger on a commercial airline on a regularly scheduled route or as a passenger for transportation only and not as a pilot or crew member; sex changes; a diagnosis or treatment received outside the United States, or its territories, that cannot be confirmed by a physician licensed and practicing in the United States. The covered person, at his or her own expense, is responsible for obtaining such confirmation.

## Termination of Certificate

Your insurance coverage under the certificate, including any attached riders, will end on the earliest of these dates: the date the policy terminates; the date the renewal premium became due once the grace period has ended if the premium remains unpaid; the date you no longer qualify as an insured or the date of your death.

## Termination of Coverage

Your insurance coverage under the policy and/or attached riders for a covered person will end as follows: the date the policy terminates; the date the certificate terminates; the date the renewal premium became due once the grace period has ended if the premium remains unpaid; the end of policy period in which we receive a written request from you to terminate the covered person's coverage; the date a covered person no longer qualifies as an insured or eligible dependent or the date of the covered person's death. APL may end coverage of any covered person who submits a fraudulent claim.

## Benefit Rider

All riders are part of the policy/certificate to which it is attached and are subject to all the provisions of the policy/certificate that are not in conflict with the provisions of the rider.

## Critical Illness Rider

Pays a benefit when a covered person has a covered critical illness, as defined in the rider. The benefit is payable once per covered person per calendar year. Once 100% of the applicable critical illness benefit amount has been paid for a covered person in a calendar year, no additional critical illness benefit amount is available for the covered person in that same calendar year.

If a covered person receives a benefit for carcinoma in situ, and is later diagnosed with another critical illness within the same calendar year, APL will pay the critical illness benefit amount less the amount previously paid for carcinoma in situ. In any calendar year, APL will not pay more than 100% of the critical illness benefit amount. Any critical illness not specifically listed in the critical illness definition is not payable under this rider. The occurrence date of the critical illness must occur on or after the covered person's effective date or the effective date of the rider, whichever is later, and while coverage is in force.

## Additional Riders

All riders are part of the policy/certificate to which it is attached and are subject to all the provisions of the policy/certificate that are not in conflict with the provisions of the rider.

## Portability Rider

When your coverage under the Group Limited Benefit Hospital Indemnity Policy terminates for reasons other than non-payment of premium, he/she may elect to continue coverage. APL must receive a completed Portability Election form and payment of the first premium for the portability coverage no later than 30 days after such termination of coverage.

The benefits, terms and conditions of the portability coverage will be the same as those under the Group Limited Benefit Hospital Indemnity Policy immediately prior to the date the portability option was elected. No changes may be made to benefit amounts, terms, or conditions after portability has been elected. Portability coverage may include any eligible dependents who were covered under the policy at the time of termination. No eligible dependents may be added to the portability coverage except as provided in the newborn and adopted children provision. Eligible dependents may be removed at any time. Premiums will be adjusted accordingly. Portability coverage will be effective on the day after coverage ends under the Policy.

Under the portability coverage, you will no longer be required to be: actively at work with the policyholder; actively at work with a member company of the policyholder; or a benefit-eligible member of the policyholder. Once portability has been elected, no further portability options are available for any person covered under the ported coverage. All future premiums due will be billed directly to you. You are responsible for payment of all premiums for the portability coverage. APL will notify you of the amount of premium due, the frequency of premium payments and the premium due dates. APL will not change the premium rate more than once in any period of six consecutive months and will give you 60 days advance written or electronic notice of any change in rates.

**Termination of Portability Rider Prior to Portability:** Prior to portability being elected, the rider will terminate on the earliest of: the end of the grace period if the premium remains unpaid; the end of the certificate period in which we receive a request from the policyholder to terminate the rider or the end of the certificate period in which APL terminates the rider.

**Termination of Portability Coverage:** Insurance under the portability privilege will end on the earliest of: the date the master policy terminates; the end of the grace period if the premium for the portability coverage remains unpaid; the end of the certificate period in which we receive a written request from you to terminate the portability coverage; the date of your death; with respect to eligible dependents, the date the covered person no longer qualifies as an eligible dependent. Once insurance under this portability provision is cancelled, it cannot be reinstated.



2305 Lakeland Drive | Flowood, MS 39232  
ampublic.com | 800.256.8606

Underwritten by American Public Life Insurance Company. All Riders are subject to all the Provisions, Conditions, Limitations and Exclusions of the Policy to which it is attached, which are not in conflict with those of the Rider. For complete benefits and other provisions, please refer to the policy/certificate/rider. This coverage does not replace Workers' Compensation Insurance. **This product is inappropriate for people who are eligible for Medicaid coverage.** | This is a supplement to health insurance and not a substitute for major medical coverage. It is NOT considered "minimum essential coverage" under the Affordable Care Act, and, therefore does NOT satisfy the mandate requirement under the Act. The insured may be subject to a tax penalty and should consult their tax advisor. | Policy Form GH17 Series | Critical Illness Benefit Rider Series | IL | Group Limited Benefit Hospital Indemnity Insurance Policy | (04/21) | URSA



# Enrollment Form

## APL: Ursa Farmers Cooperative Co. Everyday Solutions Supplemental Benefit Plan for Patron Members

Open enrollment is August 1st - September 30th please return your form no later than September 30th. You can return the form through the return envelope if received through the mail or as indicated below which you can (Mail, Text, Email, or Fax) your form in. Below also has helpful contact information for our representative if you have questions and information about an educational video to learn more about this benefit. If you have enrolled you also need to complete the APL acknowledgement form verifying you have reviewed the consumer brochures.

\* Mail: Attn: Matt Rednour. 2550 Middle Rd. Suite 300. Bettendorf, IA 52722

\* Email: [Matt@waregroupga.com](mailto:Matt@waregroupga.com) submit form and ask questions

\* Phone: 563-265-0122 submit form via text or call and ask questions

\* Fax: 563-538-7804

\* To watch a video on this supplemental plan please go to this URL or review the QR code above: <http://bit.ly/ursasupplementaleducationvideo>

\* To print more consumer brochures, enrollment forms, and APL acknowledgement forms please go to the following URL: <http://bit.ly/ursasupplementalforms>

\* Eligible to enroll: Patron Members of Ursa Farmers Cooperative Co.

\* If you are enrolling you must include your URSA Member account number where specified on your enrollment form so that billing can properly be sent.

\* Invoices for any plan you have enrolled in will be sent to you along with a copy of this form in October. The payment for this plan must be paid in full annually no later than December 1st. You will receive this invoice directly from Ursa Farmers Cooperative Co. and it will specify your options to submit payment.

Please check which focused plan you are enrolling in below or check the decline box. You can only check one between the Accident Focused or Critical Illness focused not both.

Critical Illness Focused			Accident Focused		
Individual	<input type="checkbox"/>	\$803.04	Individual	<input type="checkbox"/>	\$803.04
Individual & Spouse	<input type="checkbox"/>	\$1,609.08	Individual & Spouse	<input type="checkbox"/>	\$1,609.08
Individual & Child(ren)	<input type="checkbox"/>	\$946.92	Individual & Child(ren)	<input type="checkbox"/>	\$946.92
Individual & Family	<input type="checkbox"/>	\$1,904.04	Individual & Family	<input type="checkbox"/>	\$1,904.04
I Decline both plans <input type="checkbox"/>					

Please answer in FULL all the questions below if you have enrolled in a plan. All information will be required to issue your policy and mail to you.

Name (First, MI, Last): \_\_\_\_\_ Gender: \_\_\_\_\_ URSA Patron Member Account Number: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth (Month, Day, Year) \_\_\_\_\_ Personal Phone Number: \_\_\_\_\_

Home Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

You must answer the below in FULL if you have selected to place coverage on any dependent such as: Spouse, Civil Union Partner, or Dependent Child(ren). Please provide additional paper if not sufficient space.

Dependent 1: Name (first, MI, Last): \_\_\_\_\_ Relation (Spouse, or Dependent Child) \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Dependent 2: Name (first, MI, Last): \_\_\_\_\_ Relation (Spouse, or Dependent Child) \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Dependent 3: Name (first, MI, Last): \_\_\_\_\_ Relation (Spouse, or Dependent Child) \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Dependent 4: Name (first, MI, Last): \_\_\_\_\_ Relation (Spouse, or Dependent Child) \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Dependent 5: Name (first, MI, Last): \_\_\_\_\_ Relation (Spouse, or Dependent Child) \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

You must sign and date the below and return this completed form with the methods listed above by the due date.

Patron Member Name Printed (First, and Last): \_\_\_\_\_

Patron Member Signature: \_\_\_\_\_

Date (Month, Day, Year): \_\_\_\_\_

**Acknowledgment:**

Ursa Farmers Cooperative Co. involvement in providing the American Public Life (APL) Everyday Solutions Supplemental Benefit Plan is solely in allowing both Ware Group General Agencies and APL to design an appropriate plan to benefit their Patron Members. Ursa Farmers Cooperative Co. has provided appropriate contact information to help ensure that all Patron Members have an appropriate and equal opportunity to learn about this benefit plan of which all have the right to opt out in receiving communication for this benefit offering immediately and for the future. URSA Farmers Cooperative Co. only involvement here on out is invoicing members by the indicated above due dates to collect premiums to ensure the special group rates and special features built into the plans. No Patron Members will receive an invoice for any benefits unless otherwise indicated above the intent to enroll in a plan. All responsibilities for coverage, claims, or general inquiries regarding this supplemental benefit offering will be directed towards APL and Ware Group General Agencies. Ursa Farmers Cooperative Co. is not subject to ERISA and has no employer or employee relationship in regards to providing this benefit plan to Patron Members. No coverage will be in force unless annual premium is paid in full prior to the due date before the effective date of the coverage is to begin.

“IMPORTANT NOTE - Please read this form, **complete the highlighted areas below** and return with your enrollment form . The consumer brochure was mailed to you, but can also be found at this web link – <http://bit.ly/ursasupplementalforms> . For questions, please call Matt Rednour from Ware Group at 563-265-0122 or email [matt@waregroupga.com](mailto:matt@waregroupga.com).” .



2305 Lakeland Drive, Flowood, Mississippi 39232  
Toll Free (800) 256-8606

**ACKNOWLEDGEMENT**

Thank you for considering American Public Life Insurance Company in planning for your financial security. We appreciate the opportunity you have given us to present our products to you.

In order for you to make an informed decision regarding application for coverage(s), we have developed a detailed brochure(s) that outlines the provisions of the insurance plan(s). Please read the brochure(s) carefully and ask a licensed agent or company representative any questions you may have regarding information contained in the brochure(s).

Please remember, some group coverage(s) for which you may be applying:

- 1. may require you to be actively at work or a member of the Policyholder on the effective date of your certificate of coverage in order for your coverage(s) to begin;
- 2. may have wording that may limit benefits for a preexisting medical condition(s); or
- 3. may have wording that could limit or reduce your benefits.

**I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF CONSUMER BROCHURE(S):**

_____	_____	_____
_____	_____	_____
_____	_____	_____

_____	_____	_____
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**Signed**

**Printed Name**

**Date**

**Social Security Number**  
(may omit if available on census)

**A COPY OF THIS FORM WILL BE ENCLOSED WITH YOUR CERTIFICATE AND/OR POLICY.**