



**WHAT HEALTH INSURANCE
COMPANIES DON'T WANT
YOU TO KNOW...
CAN COST YOU MILLIONS
AT CLAIM TIME!!!**

**Avoid the Seven Deadly Sins and Most Common
Fatal Mistakes of Buying Health Insurance and...
SAVE THOUSANDS EVERY YEAR
With Better and Safer Coverage!!! (page 6)**

Introducing **THE TOTAL PROTECTION PLAN** (pages 15-18)

Josh Troxel

Insurance for the Self Employed

<http://www.selfemployedinsurancecoverage.com/>

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INTRODUCTION

The purpose of this report is to reveal some of the dark secrets, gray areas and common pitfalls as related to the purchase of health insurance... while providing you with a powerful arsenal of little known, “beat-the-system” insider strategies that will enable you to **win the health insurance game!**

This information—when acted upon—can free up literally THOUSANDS of hard-earned and wasted dollars each and every year—money that can be put to much better use in such areas as a college education fund for the children, home remodeling, additional life insurance or investments to provide for an early and comfortable retirement.

Please don't misunderstand. I am not advocating “cheap” insurance. You need a comprehensive major medical plan and, ideally, a preferred provider plan (PPO) that allows you complete freedom of choice, significant savings, and no out-of-network penalties related to emergency treatment.

I openly acknowledge a strong aversion to HMO's and will not recommend them as a way to save money. Although most people are interested in ways to safely reduce their health insurance premiums, they certainly don't want to be trapped in cost-driven HMOs where “gatekeepers” tell them and their loved ones what to do. Economic considerations often subvert good medical practice as doctors have a dangerous incentive to under-treat people—since the less they do, the more money they make! That's a pretty good deal for them... but not the patient!

HMO's generally work well when you're not sick(!) and only need routine preventive care or a physical exam. But for the seriously ill, they often provide too little, too late. That's because serious illnesses consume most of the healthcare dollar and, therefore, inspire the HMOs to impose obstacles to aggressive treatment. Although these restrictions may be good for profits, they're bad for you the patient!

I also caution you not to rely on employer-based group insurance, and explain *on page 4* how it is potentially the number one threat to your financial future!

Let's get started...

SHOULD YOU BUY INSURANCE FROM AN AGENT OR A BROKER?

When buying any kind of insurance, should you work with an insurance agent or an insurance broker? In order to know the answer, you first must understand the difference.

Captive agents are employees of an insurance company. Therefore, they represent that specific insurance carrier exclusively... just as the salesman at a Ford dealership sells Fords exclusively. No matter how good a Cadillac is, no Ford salesman can sell you one.

Some of the largest insurance companies are captive agencies.

Independent agents, or brokers, are free to represent many insurance carriers—often dozens. Thus, independent agents are free to shop the market and find the single policy, or the ideal combination of products, that provides the best value... the best coverage at the best price for their clients.

Brokers, therefore, do all the shopping for their clients, eliminating the need for their clients to shop on their own.

SUGGESTION: You should either work with *one* trusted broker or with *many* different agents... since agents will only recommend the policies of the single insurance company that they work for.

WARNING: It's not uncommon for agents to claim to be brokers in an effort to discourage their clients from shopping around and talking to the competition. If you're not sure whether you're working with a captive agent or an independent broker... ask for their business card. If it contains the name or logo of a specific insurance company, that's who they represent. Period.

EMPLOYER-BASED GROUP INSURANCE or your own INDIVIDUAL POLICY...*what's better?*

Have you ever thought about what might happen if you suffered a serious illness or injury, couldn't return to work and as a result, lost your job along with your employer-sponsored health insurance?

This is what happens to millions of Americans every year and the financial consequences are devastating.

Up to ONE MILLION mostly middle and upper-middle class families are forced to file bankruptcy every year due to medical bills they cannot pay—even though nearly 80% had health insurance (*mostly through work*) at the onset.

Employer-based health insurance is the leading cause of personal bankruptcy in America... accounting for as much as 50% of all annual bankruptcy filings!

Once “sick days” and vacation time are exhausted, few employers can afford to continue paying salaries and provide health insurance benefits for absent employees... especially while providing the salaries and benefits of their replacements! Soon these unfortunate employees are let go and their financial problems escalate beyond control.

Even people who have *retired* with employer-sponsored health benefits are in danger of losing them, as more companies renege on their promises to retirees.

SOLUTION: The “INDIVIDUAL” health insurance market is in the midst of a huge growth spurt and is rapidly replacing employer-based group insurance because *privately owned* individual health insurance is...

1. PERMANENT... once you own a policy, you **cannot** be singled out for premium increases or cancellation because of frequent “claim activity” or deteriorating health.

2. PORTABLE... the policy is not dependent upon where you work and since you own the policy, you can take it with you from job to job... *or keep it if you start your own business.*

3. AFFORDABLE... *individual health insurance policies typically cost 50% to 75% less group insurance!* Insurance companies offer huge discounts to people buying their own individual policies because, unlike group insurance, they only have to accept the folks that are relatively healthy—approximately 80% of all applicants—and can afford to charge much lower prices as a result.

By the way, in case you or someone in your family is among the 20% unable to obtain private individual coverage in the open market... don't despair! You can still get "state-guaranteed coverage" for the unhealthy family member—*a much safer scenario than remaining on an employer-based group plan*—while the rest of the family enters the 80% pool of healthy policyholders.

As for those of you that receive "free" health insurance at work, an individual policy is much safer since you will not lose your coverage if you lose your job... but that's your call. However—and this one's a no-brainer—if you pay extra to your employer in order to cover your spouse and children on the company plan, **you could be saving thousands of dollars every year by taking them off the group plan and buying them their own individual policy.** They'll also be a lot safer because they will no longer be at risk of losing their health insurance if you lose your job!

Over the last several years, new legislation and regulations have dramatically altered the health insurance industry. However, very few employees, employers, self-employed individuals... or even insurance agents (!) are aware of the major changes taking place and the opportunities to solve much of America's "healthcare crisis".

For example, did you know that employers finally have the option of getting out of "the health insurance business" and—once and for all—ending their health insurance nightmare through a *Health Reimbursement Arrangement*? **They can now allow their employees to buy their own permanent, portable and much more affordable individual health insurance policy, and reimburse each employee for some or all of their monthly premiums on a totally TAX-FREE basis!**

GETTING THE BEST VALUE—*here's what to look for... and look out for:*

1. The Deductible: This is the amount you pay in a single year before the insurance company kicks in. Unfortunately, too many insurance agents like to steer their clients toward low deductibles like \$500 or \$1000—***the absolute worst values!*** The lower the deductible, the higher the premium (the amount that you pay each month).

Since agents get paid a percentage of your premium... the lower your deductible, the bigger their commission! Obviously, the agent has a financial disincentive to save you money.

Be suspicious of insurance agents that recommend health insurance deductibles under \$1500!

REMEMBER: *Affordable* plans have deductibles of \$2500 and up. The higher your deductible, the lower your cost. In fact—and this is a major point—the money you save will almost always far exceed any potential additional out-of-pocket expenses!

WARNING: With the exception of *just one* major medical policy that I'm aware of, every health insurance program in the industry imposes additional out-of-network deductibles... as penalties for receiving non-emergency medical treatment from a non-PPO doctor or hospital. These deductibles are in addition to and often double the regular in-network deductibles!

The problem is that even if you're admitted into an in-network facility for a scheduled surgery... **the surgeon, pathologist, radiologist or anesthesiologist may not be a participating provider in your network... and you could easily be stuck with an additional \$5000 or more out-of-pocket. Ouch!**

BONUS: Would you like the name of the insurance company that offers a plan with a SINGLE DEDUCTIBLE for both in and out-of-network medical expenses? Call (608) 359-9574 and mention "**The Total Protection Plan**".

2. Coinsurance: In addition to the direct deductible in health insurance policies, there is a second “hidden deductible” known in the insurance business as coinsurance.

Coinsurance is the ratio (80/20, 60/40, 50/50, etc.) by which the insurance company and the insured share payment for eligible medical expenses after the deductible is satisfied. With regards to “individual” insurance the most common arrangement is 80/20 with a \$10,000 “stop-loss” or “coinsurance maximum”.

What this insurance industry gibberish means is that after your deductible is satisfied, the insurance company is responsible for 80% the next \$10,000 of eligible medical expenses (\$8,000) and you pay 20% (\$2,000)... after which your insurance picks up 100%... up to your policy maximum, right?

Theoretically, yes. In reality, however, as you may have guessed, things don't always go as expected, due to exclusions, waivers, waiting periods, out-of-network penalties, separate limits regarding certain conditions and services, blah, blah. **READ YOUR POLICY... or let me read it for you!**

WARNING: The overwhelming majority of policyholders have no clue as to the importance of “stop-loss”... and often wind up owning policies with extremely high coinsurance maximums. Upon diagnosis of a serious illness or injury, they discover the true meaning of “stop-loss” the hard way... with shockingly high and unaffordable—if **not unlimited**—out-of-pocket exposure!

3. Lifetime Maximum or Cap: This is the most that the plan will pay out in benefits over the lifetime of each covered person. You should be covered for at least \$2 million in total medical bills over your lifetime. But be careful—with a seriously disabling illness or accident, you could blow through that \$2 million in no time! Many plans, nowadays, pay up to \$5 million. However, be cautious of the dangerously misleading policies that promote \$5 million in total lifetime coverage, but tap out at only \$500,000 per accident or illness. Any expenses over that are totally yours! In fact, you'd need at least **10** separate medical catastrophes to ever approach \$5 million!

SUGGESTION: Find a policy that, ideally, pays up to **\$5 million** per person lifetime without separate limits per injury or illness. *They do exist.*

4. Separate Limits: Despite claiming \$2 million or more in lifetime medical benefits, many plans severely restrict the most that they'll pay for specific medically necessary services.

Most common are the dangerously inadequate limits (either per treatment or annual) for outpatient **physical, speech and respiratory therapy**. In fact, virtually EVERYONE is unaware of this hidden danger and it's a ticking, medical bankruptcy time bomb contained in almost **EVERY SINGLE MAJOR MEDICAL POLICY in the marketplace!!!**

To put things in perspective, in a speech delivered to The Million Dollar Roundtable (a prestigious international insurance industry association), a disability income insurance specialist (last name, Nichols) described his own personal tragedy—becoming a quadriplegic after a water skiing accident—and his long and arduous road to recovery.

After neck and spinal cord surgery, he began an intensive outpatient physical therapy program in order to learn to walk again. His treatment consisted of five, two-hour sessions per week at The Rehabilitation Institute of Chicago. **The total cost the first year—FOR PHYSICAL THERAPY ALONE—was over \$300,000... and that was in 1993!!!**

Fortunately, Mr. Nichols had the wisdom and foresight to own a disability policy that included additional therapy coverage, because **his health insurance plan would have excluded over 90% of the bill!** And, ironically, the health insurance coverage he had was at least 800% better than almost everything else in the marketplace!

For example...

BlueCross BlueShield of Illinois' "Cadillac" individual policy, "BlueChoice Select"... caps out at "\$3000 maximum per therapy, per calendar year."

Time Insurance (formerly Fortis) also has a **\$3000 calendar year maximum** for “Outpatient: occupational, physical and speech therapies, and cardiac rehabilitation.”

Aetna’s “Advantage Plans for Individuals, Families and the Self-Employed” limit outpatient physical therapy to **only \$600!** “Aetna will pay a maximum of \$25 per visit... 24 visits per calendar year.”

UniCare’s best individual policy limits “physical therapy, occupational therapy and acupuncture” to a “maximum payment of \$30 per visit, up to 12 visits per member, per year, for all of these services combined”... a grossly inadequate, total *potential* payout of just **\$360 per year!**

CAUTION: In addition to therapy, virtually every major carrier severely restricts benefits for **organ transplants not performed at a “Center of Excellence”**. And watch out for the dangerous limits on diagnostic testing, emergency room charges, AIDS/HIV and multiple surgical procedures!

VERY IMPORTANT SUGGESTION: Insist on a plan that pays for all of the above—up to the lifetime maximum (preferably \$5 million), without being subject to separate internal limits. Such plans, although quite rare, are available and a knowledgeable agent should be able to find an **affordable** one for you.

5. Exclusions: Be *especially* careful here. These are the services and medical conditions **not covered** by your policy! These are the things that you have to pay for yourself.

Don’t ever assume that everything is covered! After your agent finishes telling you what he or she *wants* you to hear, ask to go over the exclusions and limitations page to see what’s not covered.

If you are self-employed, an officer in a corporation, or a partner in a partnership (and have legally opted out of Workers Compensation)... stay away from policies that don’t cover injuries or illnesses related to your work (24 hour exclusion). On-the-job coverage should be provided **FREE** of charge!

Avoid policies that don't cover outpatient emergency care and outpatient therapy, and impose waiting periods—*even for emergencies*—on such conditions as any diseases or disorder of the reproductive organs (**including cancer!**), AIDS/HIV, hernia, tonsils, adenoids, gall bladder, hemorrhoids, varicose veins, middle ear disorders, bunions, spinal fusions and waiting periods for worldwide coverage!

A very common and potentially devastating exclusion to be on the look for is... **outpatient prescription drugs!** If you or someone in the family develops a serious medical condition and requires expensive and ongoing medication *in order to live*...the last thing you need is the financial stress of a \$2,000 per month (or more) uncovered medical expense!

BlueCross BlueShield of Illinois will not cover “services or supplies received during an Inpatient stay when that stay is primarily related to behavioral, social maladjustment, lack of discipline, or other antisocial actions which are not specifically the result of Mental Illness.” I have yet to find a BlueCross BlueShield agent that understands what that means!

CAUTION: Don't ever, ever, ever buy a policy that pays a specified dollar amount (usually, of course, far below the actual charges) for each type of medical service and surgical procedure performed! **These “insurance” policies are among the very worst policies on the market and are often presented as valuable “benefits” to unsuspecting self-employed association members!** Many of the biggest and best-known “independent” associations are actually **owned** by the insurance companies that they endorse!!!

6. The “Sucker’s Bet”: This is coverage that is designed to virtually guarantee that you ALWAYS pay in hundreds or thousands of dollars more in premiums than you can ever realistically collect in benefits.

MATERNITY coverage is the best example of a “sucker bet” and one of the most common rip-offs in the individual health insurance market, since it's incredibly overpriced, and those premiums are rarely recovered in a maternity claim. Most people don't understand the mathematics of health insurance and are completely unaware of what a lousy investment maternity coverage winds up being.

The insurance company limits its exposure by setting a separate benefit maximum on maternity benefits... and of course, there is always the deductible and coinsurance amounts that need to be satisfied. Plus, depending on the coverage, the age of the insured and other factors... premiums are typically an extra \$200 *and higher* per month!

To prevent people from waiting until they decide to have children before adding maternity coverage to their policy—known as “adverse selection” in the business—insurance companies typically impose a nine to 12 month waiting period (*before conception can occur*) during which **you are paying expensive maternity coverage premiums but there is NO COVERAGE in effect!!!**

Also, you **MUST** select the maternity option *at the time of application for insurance* and once you remove it, you cannot reinstate it! So if you plan on having additional children and want to space them out, ohhh... say a couple of years in between each birth... just imagine all of those months of wasted premiums—\$200, \$300 *or more* every month—with annual rate increases along with the base policy!

DON'T BE A SUCKER! If you buy your own health insurance, do **NOT** waste your hard-earned dollars on maternity “benefits”!

A BETTER IDEA: First of all, you need to *get real* and understand that you're going to pay for the birth of your children whether you give the money to the insurance company in the form of additional maternity coverage premiums or whether you pay for it, yourself, in cash... *or through a payment plan worked out with the hospital.*

Why not take those extra premium dollars that you'd be wasting on maternity coverage and put them into a no-load mutual fund where you might average 10% or more per year? Let that \$200, \$300 *or more* continue to grow until the baby is born. Any funds left over can be invested into a college education fund.

COMMON MISCONCEPTION: By far the most frequent concern we hear is, “*what if there are complications that require intensive care? That could cost hundreds of thousands or even millions of dollars in medical charges!*”

Don't worry. **Complications of pregnancy are treated by the base policy the same as an illness or injury... regardless of whether or not you carry maternity coverage!**

Just make certain, of course, that you've selected a policy that does an adequate job of covering illnesses and injuries!

7. Pre-Existing Conditions: A "pre-existing condition" is a medical problem that was diagnosed or treated—or was obviously present—during the 6 to 24 month period prior to buying a health insurance policy. *The shorter the "look-back" period, the better the policy.*

After reviewing an application for health insurance, the *underwriter* may issue coverage with exclusions for "pre-existing conditions" on one or more family members. In effect, certain medical conditions may be excluded from coverage for a certain period of time or for as long as you own the policy. *If you or someone in your family has a pre-existing medical condition, it's important to know when the insurance company will begin to cover the bills!*

There is no standard underwriting process that's universal to all insurers as far as their assessment of specific health risks. Nor are the definitions of a pre-existing condition or the penalties the same among all insurance companies... *and therein lies the danger!*

You need to be extremely cautious upfront in order to prevent a medically generated financial disaster at claim time... finding out what's NOT covered when it's too late!

Here's what to look for...

By far, **the best and safest pre-existing condition language** that you'll find in an individual health insurance policy... is contained in *all* of the major medical products underwritten by Guarantee Trust Life Insurance Company:

"Health conditions duly disclosed in the application for coverage of the covered person and otherwise covered by this policy, unless the condition is specifically excluded by endorsement or rider attached to

the policy or certificate, are covered from the effective date of coverage under the policy.”

TRANSLATION: As long as the pre-existing condition is disclosed on the application, and not too serious—as to cause the company to issue a written exclusion or rider—**THE CONDITION IS COVERED FROM DAY ONE!!!**

*Here’s a couple of typical examples of what to look **out** for...*

BlueCross Blue Shield: “Pre-existing Conditions are those health conditions which were diagnosed or treated by a Provider during the 12 months prior to the coverage effective date, or for which symptoms existed which would cause an ordinarily prudent person to seek diagnosis or treatment. Any Pre-existing Condition will be subject to a waiting period of 365 days.”

UniCare: “Coverage will not be provided for the 12 months following the effective date of this plan for medical conditions that existed in the 12 months prior to the effective date.”

TRANSLATION: Everything pre-existing—for as long as 12 months prior to coverage—**WILL BE EXCLUDED FROM COVERAGE** for a period of 12 months *after* the policy takes effect!!!

THE DANGER: If, for example, a person taking prescription medicine for elevated cholesterol or high blood pressure is issued a policy and suffers a heart attack within the first 12 months of coverage, the company can deny payments... claiming that the use of medicine was to control a pre-existing heart-related condition—and **pre-existing conditions are not covered for the first 12 months after the policy effective date—even though no formal exclusion or rider was attached to the policy!!!**

Also, certain insurance companies are notorious for looking over your application and your medical records with a magnifying glass **after** you become ill... looking for something that you failed to mention. It’s called **“post-claim underwriting”**.

If they find something that *they* consider a material omission, they may **reject** your claim and **revoke** your policy—**at the worst possible time**—even if the omission has nothing to do with your current illness!

My BEST Advice: Health insurance is highly complex and not meant to be a do-it-yourself project for amateurs.

Besides, insurance companies are legally required to charge the same amount of premium whether you buy your policy directly from the insurance company or from the friendly, local home and auto agent... **or whether you leverage the experience and expertise of a licensed and independent health insurance specialist.**

AFFORDABLE and SAFE policies do exist but most agents tend to take “the path of least resistance” and sell the familiar brand names. As a result, some of the biggest and best-known companies realize that they can put an inferior product out into market and be enormously successful based on name recognition alone!

Ultimately, the big loser is the consumer because when it comes to health insurance—and all its variables—one “false move” can mean the difference between financial security and medical bankruptcy!

To the Uninsured: More Americans than ever are going without health insurance. At this writing, their number exceeds 45 million, and every year another half million people join the ranks of the uninsured—usually because they **falsely** believe that decent coverage costs far more than they are able to pay. Others are just plain ignorant in thinking that the uninsured receive equal care, especially if seriously or chronically ill.

If you're uninsured, you must make **every** sacrifice necessary to buy health insurance. We're all too familiar with stories about families wiped out by a breadwinner's cancer, a newborn's deformity or a paralyzing accident. And, please, apply for coverage while you and your family are in good health. If you wait until an ailment develops, you'll pay more for your coverage—if you can even get coverage at all!

Remember, when it comes to individually owned policies, *“if you need it and you ain't got it... you can't get it!”* And studies show that **the uninsured go to the hospital sicker, and are much more likely to die when their illness is serious!**

Save **THOUSANDS** per year with **BETTER** coverage...

THE TOTAL PROTECTION PLAN

STEP #1: Make sure you have a safe, high-quality major medical program in place... and that you're not paying a dollar more than necessary.

Look, I admit it. As great a humanitarian and as altruistic as I am, I don't write and give away FREE reports for my health (*pun intended*). I'm extremely passionate about the health insurance business and considered to be an authority. Also, my clients LOVE me because I truly care about them... and I want to be YOUR trusted advisor as well.

So, if I could show you the NUMBER ONE health insurance plan in America—the absolute BEST VALUE in the individual major medical marketplace... well, obviously, you'd want to know about it, wouldn't you?

STEP #2: INCREASE YOUR DEDUCTIBLE BY \$2500. As crazy as it seems, **health insurance companies, on average, will lower a typical family premium by approximately 120% of your increase in deductible!**

DO THE MATH (\$2500 x 120%): A \$2500 increase in deductible should lower your annual payments by \$3000—which frees up \$250 per month that can be put to much better use, right?

DO MORE MATH (\$3000 - \$2500): Even in a very bad year (medically), your additional \$2500 in deductible exposure is offset by your \$3000 in premium reduction... netting you a \$500 gain! **YOU CANNOT LOSE!**

STEP #3: Protect your INCOME and ASSETS in the event that you survive a serious illness but aren't able to return to work!

Three IMPORTANT questions for you to carefully consider:

1. Has your financial advisor (*hopefully this isn't your unemployed neighbor*) shown you a way to protect your **financial health** if you're diagnosed with cancer or suffer a heart attack or stroke?

2. Assuming you already have disability income insurance (*most people don't*) and you're diagnosed with cancer, a terminal illness, need an organ transplant, or suffer a heart attack, stroke or kidney failure... would you rather have to wait 90 days before receiving only 60% of your taxable monthly income, **or get an up front, lump sum benefit of up to \$200,000 paid directly to you, upon diagnosis, with no waiting periods, no employment or occupational restrictions, no income requirements or continuing evidence of disability?!!**

3. Would you rather have a heart attack and lose your house... or have a heart attack and pay off your mortgage?

“CRITICAL ILLNESS INSURANCE” pays **living** benefits to an individual upon **diagnosis** of cancer, heart attack, stroke, kidney failure, terminal illness, total disability, the need for an organ transplant, etc.

The key is that payment is triggered by **diagnosis**. Benefits are not tied to any reimbursement of expenses, like health insurance, and you can use the money in any way you choose—to replace lost income, pay for experimental treatment, pay off personal debts, including mortgages and other expenses. **There are NO LIMITATIONS on how the money is to be used!**

The vast majority of Americans have never heard of Critical Illness Insurance because most insurance agents haven't either! They prefer to sell mortgage life insurance (*another “sucker's bet”*) and yet, according to HUD, **only 3% of mortgage foreclosures are the result of death and 48% are the result of a severe financial hardship caused by a serious illness!**

A recent study conducted by Harvard University found that 50% of the bankruptcies in America were the result of a medical emergency... and that **over 75% of those folks had health insurance at the onset!**

You can have the greatest health insurance policy in America, like the plan described on page 18, with no separate internal limits or exclusions, out-of-pocket elimination benefits and all of that wonderful stuff... and still get wiped out because health insurance is designed to cover medical expenses only. It's not going to pay the mortgage or rent, college tuition, car payments, utility bills or buy food for the family. It won't pay your health or life insurance premiums (*you better not let those policies lapse... when you're critically ill*). This is where the enormous strength of a critical illness policy truly lies—as a source for much needed funds in a time of medical emergency.

IS IT EXPENSIVE? No. It's far more expensive not to own a critical illness policy... and **I have still not found another insurance product that has the ability to positively impact another person's life as quickly and completely as critical illness insurance!** Period.

Remember the \$250 per month (\$3,000 annually) that we saved by increasing the health insurance deductible by \$2,500?

Well, suppose we used \$100 to invest in Critical Illness coverage for both spouses in the family—\$50 on each—and let's assume that they're non-tobacco users in their early to mid 30's. They would now each have a lump-sum cash benefit of around **\$70,000**—paid directly to them **on diagnosis**, at a time they need it the most... and to be used however they wish!

They would have choices that they might not otherwise have!

They would also have what I refer to as a...

FULLY-LOADED, TOTAL PROTECTION PLAN

Safe and affordable, permanent and portable major medical coverage with minimal out-of-pocket exposure—along with much needed, and often neglected, income and asset protection—*all for over \$800 LESS than the typical unsafe and over-priced “coverage” that most people settle for!*

A FINAL WORD

Quality health insurance does not have to be expensive. Often acting on the misleading “advice” of so called “experts”, the vast majority of people who buy their own—the self-employed and others without employer subsidized coverage—are grossly overcharged for the quality of coverage they receive.

I’ve used the examples in this report to shock many of my clients into reality and, hopefully, I’ve provided you with enough valuable information to help you demand and receive much greater value and safety for your hard-earned dollars. Nothing would satisfy me more.

Thank you for allowing me to share this material with you. Since you’ve gotten this far, you probably realize that you’re paying too much for too little and perhaps you’re a little sore about it. You may even be motivated to do something about it.

I invite you to take the first step today. Call me at **(608) 359-9574** for a no-obligation evaluation of you health insurance needs. There is **NO CHARGE** for an initial consultation.

ABOUT THE AUTHOR

Josh Troxel is a health insurance specialist. He is committed to preserving the health and wealth protection interests of his clients and sincerely believes that quality, affordable health insurance should top your list of necessities—right after food, shelter and clothing.

Mr. Troxel states that “being without or having inadequate health insurance because you mistakenly feel you don’t need it or can’t afford it, endangers your personal solvency. A single serious illness or accident could take away all you have—your health, income, assets and family’s future.”

“I have the knowledge and satisfaction of knowing that when I properly structure and place a policy, I have performed a valuable service for my client—and it’s always nice to be part of a win-win situation.”

Josh Troxel can help you get the coverage you need at a price you can afford. Call **(608) 359-9574** today for a no-obligation, free consultation or email Josh@selfemployedinsurancecoverage.com.