



COMPLETE THE FOLLOWING INFORMATION ABOUT YOURSELF:

Applicant: Name, Date of Birth, Age, Sex, Social Security Number (SSN #), Occupation, Telephone, Street Address, City, State, Zip, Billing Address (if different), City, State, Zip, E-mail address

COMPLETE THE FOLLOWING TO INSURE YOUR SPOUSE AND/OR CHILDREN:

Spouse: Name, Date of Birth, Age, Sex, SSN #, Occupation, Child's Name, Date of Birth, Age, SSN #

COMPLETE THE FOLLOWING PLAN CHOICES:

A. Coverage Effective Date: Day after US Post Office Date Stamp, Later Effective Date; B. Coverage Length: Single Payment, Monthly Payment; C. Coinsurance; D. Deductible; E. Payment Method

SSL-STM-0506 APP-FL

ANSWER THE FOLLOWING MEDICAL HISTORY QUESTIONS:

I understand that any material misstatement or omission of information made on this form will be considered a misrepresentation and may be the basis for later rescission of my coverage and that of my dependents.

- 1. Will there be any other health insurance in force on the policy date?
2. Is the proposed insured, spouse, or any dependent child now pregnant?
3. Has any person applying for coverage been declined for health insurance for a condition that is still present?
4. Is any proposed insured currently eligible for Medicaid?
5. Are you or any person proposed for coverage over 300 pounds if male or over 250 pounds if female?
6. Within the past 5 years have you or any person proposed for coverage received an abnormal test report, been diagnosed with, treated by or received follow-up care with a member of the medical profession or taken medication for:

Table with 3 columns of medical conditions: heart disorder, stroke, cancer, tumor; emphysema or COPD, diabetes, liver disorder, kidney disorder; degenerative disc disease, rheumatoid arthritis, degenerative joint disease, alcohol abuse, hemophilia.

- 7. Have you or any person proposed for coverage EVER tested positive for exposure to the HIV infection, or been diagnosed as having ARC, or AIDS caused by the HIV infection or other sickness or condition derived from such infection?
8. Has any person proposed for coverage not been a legal resident of the United States for the last 12 consecutive months?

NOTE: IF "YES" IS ANSWERED ON ANY QUESTION 1 THROUGH 8, COVERAGE CANNOT BE ISSUED.

- 1. I agree that coverage will not become effective for any person whose medical history changes prior to coverage approval...
2. I hereby request coverage issued to the group policyholder by the insurer and understand that if the coverage applied for becomes effective, I agree to all terms of the group policy...
3. I understand that the broker who solicited this application was acting as an independent contractor...
4. I have read this application and have verified that all of the information provided in it is complete, true and correct...
5. All information provided will be held in strictest confidence.

I understand that this coverage will not pay benefits for a disease or physical condition that I now have or have had within 5 years of my application for coverage.

Signature of Applicant: Date: Signature of Spouse: Date:

Fraud Warning: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony in the third degree.

The policy is primarily governed by the laws of the District of Columbia. As a result, all of the rating laws applicable to policies filed in this state do not apply to this coverage...



# SECURE SHORT TERM MEDICAL INSURANCE (Florida)

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

**If you selected payment by credit card or monthly bank draft, please complete the applicable request form below:**

**CREDIT CARD PAYMENT REQUEST:**

I authorize Health Plan Administrators, Inc. to charge my credit card premium and fees once for Single Pay Option; or the 1st month and each month thereafter for the Monthly Pay Option.

VISA     MASTER CARD     DISCOVER CARD

Account Number \_\_\_\_\_ / \_\_\_\_\_  
Expiration Date

Print Accountholders Name (As it appears on the card.) \_\_\_\_\_

Signature of Cardholder \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

**AUTOMATIC CHECK WITHDRAWAL REQUEST:**

**Attach a voided check and a check for the first month premium and fees.**

Your Standard Security Life Insurance Company of New York monthly premium and fees will automatically be withdrawn from your checking account until the term of insurance expires.

Print Name of Bank or Institution \_\_\_\_\_

Address of Bank or Institution \_\_\_\_\_

I request that you pay and charge my account debits drawn from my account by Health Plan Administrators, Inc. to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may at any time end this agreement by giving 30 days advanced written notice to me. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

**STM RATE CALCULATION INSTRUCTIONS:**

Complete the calculations based on the coverage options you selected on the application. Note, after the 10 day free look period, premiums are not refundable.

	SINGLE PAY (Daily Rates Minimum of 30, Maximum of 180)	MONTHLY PAY (Monthly Rates)
1. Applicant:	\$	\$
2. Spouse:	\$	\$
3. Child:                      Multiply (x) by # ____ of children (Pay for a maximum of 3)	\$	\$
4. Subtotal:                      Add lines 1, 2 and 3	\$	\$
5. Single Payment Option:      Multiply (x) daily rate by # ____ of Days (Minimum of 30 days)	\$	NA
6. Add Monthly Administration Fee:	<b>\$15.00</b>	<b>\$15.00</b>
7. Add Association Dues:      (This is paid once per year.)	<b>\$10.00</b>	<b>\$10.00</b>
8. Final Total:	\$	\$

**FOR AGENTS USE ONLY:**

Include a current copy of your license and the completed HPA License Request Form with your 1st application.

Agent's Full Name \_\_\_\_\_

HPA # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

Email \_\_\_\_\_

GA Name \_\_\_\_\_ HPA # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ Email \_\_\_\_\_

MGA Name \_\_\_\_\_ HPA # \_\_\_\_\_

Long Term Consumer Care Inc. \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ T0017000000 \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ Email \_\_\_\_\_

**Make personal check or money order payable to:  
Health Plan Administrators, Inc.**

**Mail your application and initial payment to :  
HPA, Inc. , P.O. Box 15250 Rockford, IL 61132-5250**

**Save time and postage, if you pay by credit card, fax both sides of the application to: 1-815-633-0277**