SECURE STM
(Maine)

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK
SHORT TERM MEDICAL INSURANCE APPLICATION

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 #__________
Child's Name ______________________________
Date of Birth __________ Age____ SSN #__________
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:** *Specify number of days of coverage* ____ days *(minimum 30 days, maximum 180 days) or*
□ **Monthly Payment:** Up to 6 Months
□ **Monthly Payment:** Up to 12 Months

C. Coinsurance: □ 80/20 of $5,000 □ 50/50 of $5,000

D. Deductible: □ $250 □ $500 □ $1,000 □ $2,500

E. Optional Benefits
□ Serious Mental Illness and Home Health Care
□ Domestic Partner

F. Payment Method: □ Check or Money Order
□ Credit Card □ Monthly Automatic Bank Withdrawal

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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. In the event of rescission or termination for any reason, the Insurer shall have the right to deduct any premium due and unpaid from any claims payable to me or my dependents.

1. Will there be any other health insurance in force on the policy date?........□Yes □ No
2. Is the proposed insured, spouse, or any dependent child now pregnant?........□Yes □ No
3. Has any person applying for coverage been declined for health insurance for a condition that is still present?........□Yes □ No
4. Is any proposed insured currently eligible for Medicaid?........□Yes □ No
5. Are you or any person proposed for coverage over 300 pounds if male or over 250 pounds if female?........□Yes □ No
6. Within the past 5 years have you or any person proposed for coverage been aware of, 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:

■ heart disorder including but not limited to heart attack	■ emphysema or COPD (chronic obstructive pulmonary disease)	■ degenerative disc disease or herniated disc
■ stroke	■ diabetes	■ rheumatoid or psoriatic arthritis
■ cancer	■ liver disorder	■ degenerative joint disease of the knees or hips
■ tumor	■ kidney disorder other than stones	■ alcohol abuse or chemical dependency
		■ hemophilia

........□Yes □ No

7. Have you or any person proposed for coverage been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex, or received treatment from a member of the medical profession for AIDS or ARC? Answer this question "no" if you have tested positive for HIV but have not developed symptoms of the disease AIDS........□Yes □ No
8. Has any person proposed for coverage not been a legal resident of the United States for the last 12 consecutive months? ....□Yes □ No
9. If you, your spouse or any dependent combine this Policy with all prior short term policies, will it exceed 12 months of uninterrupted coverage with this carrier? ....□Yes □ No

NOTE: IF "YES" IS ANSWERED ON ANY QUESTION 1 THROUGH 9, COVERAGE CANNOT BE ISSUED.

1. I agree that coverage will not become effective for any person whose medical history changes prior to coverage approval, such that the person's answer would be "yes" to any of the Medical History questions in this application. If such person is the Applicant, coverage is automatically declined for all persons included in this application.
2. I hereby request coverage issued by the insurer and understand that if the coverage applied for becomes effective, I agree to all terms of the policy. I understand that health insurance benefits are excluded for pre-existing conditions.
3. I understand that the broker who solicited this application was acting as an independent contractor and not as an agent of the Insurance Company. I further acknowledge that the person who solicited this application and upon whose explanation of benefits, limitations or exclusions we relied, was retained by me as my agent, and that such person has no right to bind or approve coverage or alter any of the terms or conditions of the policy.
4. I have read this application and have verified that all of the information provided in it is complete, true and correct, and is all within my personal knowledge. I agree to immediately notify the insurer of any changes in any of the information contained in this form which may occur prior to the approval of coverage. I understand that the authorization to release medical information excludes disclosure of the result of a test for HIV if the applicant has tested positive for HIV but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS.
5. All information provided will be held in strictest confidence. My personal health information is protected at all times and may only be released with my express written authorization to do so.
6. All statements and descriptions in the application for insurance are deemed to be representations and not warranties.
7. I understand that this short term policy does not count as creditable coverage toward any **individual** health insurance issued to me **after** this policy ends. I acknowledge that this means that continuity rights may be lost, and I may not be able to limit or extinguish the effect of preexisting condition exclusions in an individual policy. This short term policy counts as creditable coverage only for **group** health insurance issued to you after this short term policy ends. **I understand that this coverage will not pay benefits for a disease or physical condition that I now have or have had within 12 months of my application for coverage.**

Signature of Applicant: ______________________________ **Date:** ______________
Signature of Spouse: ______________________________ **Date:** ______________

Fraud Warning: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

The Credit Card / Automatic Bank Withdrawal request forms and rate calculation instructions are on the reverse side.

SECURE SHORT TERM MEDICAL INSURANCE (Maine)

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

____
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

ABOUT THE OPTIONAL MAINE COVERAGE'S*:

If the primary Covered Person selects these coverage's and the required additional premiums are paid, the following coverage's will apply during the Coverage Period.

Serious Mental Illness -The Coinsurance Percentage for the medically necessary and appropriate treatment and diagnosis of the following mental illnesses: Schizophrenia; Bipolar disorder; Pervasive developmental disorder, or autism; Paranoia; Panic disorder; Obsessive-compulsive disorder; or Major depressive disorder.

Home Health Care - Covered Expenses will include those listed below of a home health care provider for home health care services up to 4 consecutive hours in a 24-hour period of home health care service are considered as one home health care visit and not to exceed the maximums below:

Maximum Benefit Amount: $40 per 8-hour shift
Maximum Benefit Period: 40 shifts per Coverage Period

Charges for home health care, (up to the Maximum Benefit Amount shown above) up to a maximum of 90 visits in any 12 consecutive month period for: Part-time or intermittent home nursing care by or under the direction of a graduate registered Nurse; Home Health Aide services that are Medically Necessary as part of the Home Health Care Plan; physical, respiratory, occupational, or speech therapy and Nutrition counseling.

Domestic Partner - Your Spouse will include a Domestic Partner. Your Domestic Partner must have signed an affidavit attesting that You and Your Domestic Partner have met the Domestic Partner definition and show documentation of joint ownership or occupancy of real property, such as a joint deed, joint mortgage or a joint lease, or the existence of a joint credit card, joint bank account or powers of attorney in which each Domestic Partner is authorized to act for the other.

Coverage for Your Domestic Partner will terminate upon notification that the Domestic Partner relationship has terminated. You may not enroll another individual as a Domestic Partner until 12 months after the termination of coverage for a prior Domestic Partner.

** This is a brief outline of Maine's Optional Coverage, please review the Amendatory Endorsement Optional Benefit form*

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:______________________ Company Name:______________________
HPA #:____
Address: ______________________ City:______________ State:________ Zip:________
Phone #: ______________ Fax #: ______________ Email: ______________
GA Name: ______________________ HPA #:______________________
Address: ______________________ City:______________ State:________ Zip:________
Phone #: ______________ Fax #: ______________ Email: ______________
MGA Name: Long Term Consumer Care Inc.___________HPA #:_T0017000000______________
Address: ______________________ City:______________ State:________ Zip:________
Phone #: ______________ Fax #: ______________ Email: ______________

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. Optional Domestic Partner Benefit: (Maine residents)	**Add $.17** (cents) **per day per policy for Single Pay** **Add $5.10 per policy per month for Monthly Pay**	$	$
6. Optional Serious Mental Illness and Home Health Care benefit: (Maine residents)	**Add $.55** (cents) **per person to be insured per day for Single Pay; Add $16.50 per person to be insured per month for Monthly Pay**	$	$
7. Single Payment Method:	Multiply (x) daily rate by # ____ of Days (Minimum of 30 days)	$	NA
8. Add Monthly Administration Fee:		**$15.00**	**$15.00**
9. Add Enrollment Fee:	(This is paid once per application.)	**$10.00**	**$10.00**
10. **Final Total:**		$	$

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

SECURE STM Cal. Chart ME 11-07