



**SECURE STM
(New Hampshire)**

**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

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

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

E. Optional Maternity Benefit Coverage Yes No

F. Payment Method: Check or Money Order

Credit Card Monthly Automatic Bank Withdrawal

SSL-ISTM-0506-APP-NH

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:

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

7. Have you or any person proposed for coverage been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex, or any other immune system disorder?..... 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. Has any person proposed for coverage been covered under three or more short-term policies during the past 12 months? If "yes" then this Policy cannot be issued. 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.
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.

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:** _____

The policy provides limited benefits. Review your policy carefully.

Fraud Warning: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.

