SECURE STM
(South Dakota)

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

SSL-ISTM-0506-APP-SD

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 any other immune system disorder? 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

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, 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 acknowledge that this plan may cause me to lose HIPAA rights (guarantees of eligibility for insurance in certain circumstances) in South Dakota.
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 in the past 12 months.

Signature of Applicant: ______________________________ **Date:** ________________

Signature of Spouse: ______________________________ **Date:** ________________

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.

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

SECURE SHORT TERM MEDICAL INSURANCE (South Dakota)

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:		**$15.00**	**$15.00**
7.	Add Enrollment Fee:	(This is paid once per year.)	**$10.00**	**$10.00**
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