



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-STM-0506-APP-TX

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?
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 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
stroke
cancer
tumor

- emphysema or COPD (chronic obstructive pulmonary disease)
diabetes
liver disorder
kidney disorder other than stones

- degenerative disc disease or herniated disc
rheumatoid or psoriatic arthritis
degenerative joint disease of the knees or hips
alcohol abuse or chemical dependency
hemophilia

- 7. Have you or any person proposed for coverage been diagnosed by a physician 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.
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, 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 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. 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: _____

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.



SECURE SHORT TERM MEDICAL INSURANCE (Texas)

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)
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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 Association Dues: (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