

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's 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 9 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

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? 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.
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.

PAYMENT AUTHORIZATION:

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 of 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

Secure STM Unisex Rates Montana

Underwritten by Standard Security Life Insurance Company of New York

80% of \$5,000 Co-insurance Option**

Rates Effective January 1, 2009 through June 30, 2009

Deductible	\$2,500	\$1,000	\$500	\$250
Single Pay Daily (30 to 180 days)**				
Age/Area	E G H	E G H	E G H	E G H
2-19	1.39 1.54 1.61	1.77 1.97 2.07	2.61 2.91 3.07	3.49 3.90 4.11
20-24	1.60 1.77 1.85	2.04 2.27 2.38	3.02 3.37 3.55	4.05 4.53 4.78
25-29	1.47 1.63 1.70	1.88 2.08 2.19	2.74 3.06 3.22	3.69 4.13 4.35
30-34	1.95 2.13 2.23	2.46 2.71 2.83	3.50 3.88 4.07	4.61 5.14 5.40
35-39	2.21 2.43 2.54	2.79 3.08 3.22	4.03 4.48 4.71	5.36 5.99 6.30
40-44	2.57 2.83 2.97	3.26 3.61 3.78	4.75 5.30 5.57	6.33 7.07 7.45
45-49	3.04 3.36 3.53	3.89 4.32 4.54	5.73 6.40 6.74	7.66 8.58 9.04
50-54	3.75 4.17 4.38	4.83 5.38 5.66	7.15 8.01 8.43	9.63 10.80 11.38
55-59	4.55 5.07 5.33	5.93 6.63 6.98	8.85 9.93 10.46	11.98 13.45 14.18
60-64	5.46 6.10 6.42	7.14 7.99 8.42	10.71 12.02 12.67	14.52 16.31 17.21
Per Child	1.11 1.23 1.29	1.40 1.56 1.64	2.07 2.32 2.44	2.79 3.12 3.29
Deductible	\$2,500	\$1,000	\$500	\$250
Monthly Pay (Up to 6 months)**				
Age/Area	E G H	E G H	E G H	E G H
2-19	50.26 55.75 58.49	64.52 71.83 75.49	95.88 107.21 112.88	128.67 144.20 151.97
20-24	57.87 64.32 67.55	74.50 83.09 87.38	111.09 124.37 131.01	149.57 167.79 176.90
25-29	53.12 58.96 61.89	68.32 76.12 80.02	100.63 112.57 118.54	136.27 152.78 161.03
30-34	69.17 76.11 79.59	88.18 97.56 102.25	127.14 141.52 148.70	168.95 188.69 198.56
35-39	79.15 87.37 91.48	100.53 111.49 116.98	147.10 164.03 172.50	196.99 220.32 231.99
40-44	92.45 102.38 107.35	118.11 131.33 137.94	174.18 194.59 204.79	233.10 261.06 275.04
45-49	110.03 122.22 128.31	141.87 158.13 166.27	210.77 235.87 248.42	282.99 317.35 334.53
50-54	136.64 152.24 160.03	177.03 197.80 208.19	263.99 295.91 311.87	356.64 400.44 422.34
55-59	166.58 186.01 195.73	218.37 244.44 257.48	327.66 367.74 387.78	444.55 499.62 527.15
60-64	200.79 224.61 236.52	263.51 295.37 311.30	397.03 446.01 470.50	539.58 606.84 640.46
Per Child	40.16 44.67 46.92	51.09 57.00 59.95	76.27 85.41 89.98	102.88 115.43 121.71
Deductible	\$5,000	\$2,500	\$1,000	\$500
Monthly Pay (Up to 9 months)**				
Age/Area	E G H	E G H	E G H	E G H
2-19	65.30 72.71 76.41	73.34 81.79 86.01	95.29 106.55 112.18	143.58 161.02 169.75
20-24	74.81 83.44 87.75	85.05 94.99 99.96	110.66 123.88 130.49	166.99 187.44 197.66
25-29	68.95 76.83 80.77	77.73 86.74 91.24	101.15 113.15 119.15	150.89 169.28 178.47
30-34	88.89 98.37 103.10	98.40 109.10 114.44	127.67 142.11 149.33	187.66 209.79 220.86
35-39	102.06 113.22 118.80	113.77 126.43 132.76	146.69 163.57 172.01	218.39 244.46 257.50
40-44	119.62 133.03 139.74	134.25 149.54 157.18	173.76 194.11 204.29	260.09 291.51 307.22
45-49	143.76 160.27 168.52	161.32 180.08 189.46	210.34 235.38 247.90	316.42 355.06 374.39
50-54	179.61 200.71 211.27	202.29 226.30 238.31	264.48 296.46 312.45	398.36 447.51 472.08
55-59	220.58 246.94 260.11	248.38 278.30 293.26	328.13 368.27 388.34	496.39 558.11 588.97
60-64	266.67 298.94 315.07	301.06 337.73 356.07	397.63 446.68 471.21	603.21 678.62 716.32
Per Child	51.82 57.83 60.83	59.14 66.08 69.55	75.97 85.06 89.61	114.74 128.81 135.84

*The \$5,000 deductible for Single Pay and Monthly Pay Up to 6 Months is available online at www.hpainsurance.com. The 50% coinsurance option for all coverage lengths is available online.
 Standard Security Life Insurance Company reserves the right to decline applications received using outdated rates and zip code areas. Please call your agent or HPA at 1-800-277-3323 ext. 3 for rates effective 7/1/09.
 **The monthly rates listed include the following Communicating for America (CA) STM Enhancement Series fees: \$5 per dependent child; \$7.50 per person in age bands 2-29; and \$15 per person in age bands 30-64. The daily rates listed include the following Communicating for America (CA) STM Enhancement Series fees: \$.17 cents per dependent child; \$.25 cents per person in age bands 2-29; and \$.50 cents per person in age bands 30-64.
 ***Note: You pay for a maximum of up to three dependent children, regardless of the number eligible children to be insured. Please list all of your eligible dependent children to be insured on the application for insurance.

Montana Zip Area Rate Classifications

Zip Prefix	Area Letter
590-593, 595-596	H
594, 597	E
598-599	G

How to Calculate Your Rates

There are three Secure STM rate tables for each Coverage Effective Date Rate charts of 1/1/09 through 6/30/09:

1. Single Pay for 30 to 180 days
2. Monthly Pay for 1 to 6 months
3. Monthly Pay for 1 to 9 months

Referring to the applicable rate chart, you must locate each of the following:

1. Your Deductible choice
2. Age for each to be insured

Simply follow the steps listed on the Short Term Medical Rate Calculation Instructions to calculate your cost.

About the STM Enhancement Series

As a member of Communicating for America* (CA) Healthy Lifestyle Advocates, you will receive the following with this enhancement series: • Nurse-on-call access to a registered nurse 24 hours a day, seven days a week • Prescription drugs—up to 15%-60% off on generic drugs and 15%-25% off on brand-name prescriptions at more than 45,000 pharmacies nationwide

**The Communicating for America (CA) Healthy Lifestyle Enhancement Series is not an insurance benefit, nor is it affiliated with Standard Security Life Insurance Company of New York or a part of the STM insurance plan. CA provides access to discount services administered by CAREINGTON International. Enhancement series benefits may vary by state.*

How to Apply for Child Only Coverage

The minimum age is 2 years for child only coverage. Use the 2-19 rate for either the male or female, based on the gender of the youngest child; then use the per child rate for each of the other siblings to be insured. ***The parent or legal guardian must print their name as applicant and complete the remainder of the application on behalf of the child(ren). The parent or legal guardian must sign and date the application.*** Please note on the application if coverage is for child only.

How to Apply for Dependent Children Coverage

Your dependent children must be unmarried and under age 19 (or under age 25 and a full time student). List all of your eligible dependent children to be insured on the application for insurance. You only pay for a maximum of up to three dependent children, regardless of the number of eligible dependent children to be insured.

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

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	MONTHLY PAY
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:	Multiply (x) daily rate by # ____ of Days (Minimum of 30 days and maximum of 180)	\$	NA
6. Add Monthly Administration Fee:		\$15.00	\$15.00
7. Add One Time Enrollment Fee:		\$10.00	\$10.00
8. Final Total:		\$	\$

Note: These rates and zip areas apply to new coverage effective dates 1/1/09 through 6/30/09 for the 80% Coinsurance Option. This plan is available in other states. Please call your agent or HPA at 1-800-277-3323 ext. 3 for rates effective 7/1/09 and STM state availability.

FOR AGENTS USE ONLY:

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

Agent's Full Name: Long Term Consumer Care, Inc. / Ronald Hill			
HPA # T0017000000			
Address	City	State	Zip
Phone # 1-800-544-9505	Fax #	Email	
GA Name		HPA #	
Address	City	State	Zip
Phone #	Fax #	Email	
MGA Name	HPA Code #	Phone #	
Address	City	State	Zip