IAC
Insurers Administrative Corporation

TEMP MED STM
(Texas)

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 _____
Occupation _____ Telephone _____
Street Address _____
City _____ State _____ Zip _____
Billing Address (if different) _____
City _____ State _____ Zip _____
Email address _____

COMPLETE THE FOLLOWING TO INSURE YOUR SPOUSE AND /OR CHILDREN:

Spouse's Name _____
Date of Birth _____ Age _____ Sex _____
Social Security Number _____
Occupation _____
Child's Name _____ Date of Birth _____ Age _____
Social Security Number _____
Child's Name _____ Date of Birth _____ Age _____
Social Security Number _____
Child's Name _____ Date of Birth _____ Age _____
Social Security Number _____
Child's Name _____ Date of Birth _____ Age _____
Social Security Number _____

COMPLETE THE FOLLOWING PLAN CHOICES:
Choose only one for each A, B, C, D and E.

A. Coverage Effective Date:
❑ Day after US Post Office Date Stamp
❑ Later Effective Date: _____

B. Coverage Length:
❑ Single Pay (Minimum of 30 days, maximum of 180 days)
Enter #____ Days
❑ Monthly Pay - up to 6 months
❑ Monthly Pay - 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 (MasterCard, Visa or Discover)
❑ Monthly Automatic Bank Withdrawal

SSL-STM-1104-APP-TX

ANSWER THE FOLLOWING MEDICAL HISTORY QUESTIONS:

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. Is any proposed insured currently eligible for Medicaid? ❑Yes ❑No
4. Has any person proposed for coverage been declined for health insurance in the past 12 months? ❑Yes ❑No
5. Within the past 5 years have you or any person proposed for coverage been aware of, diagnosed, treated by a member of the medical profession, or taken medication for cancer or tumor, stroke, heart disease including heart attack, chest pain or had heart surgery, COPD (chronic obstructive pulmonary disease) or emphysema, liver disorder, degenerative disc disease or herniation/bulge, rheumatoid arthritis, degenerative joint disease of the knee, insulin-dependant diabetes alcohol abuse or chemical dependency? ❑Yes ❑No
6. 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. ❑Yes ❑No
7. 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 7, 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 under the policy issued to the group policyholder by the insurer and understand that if the coverage applied for becomes effective, I agree to all the 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. Your personal health information is protected at all times and may only be released with your 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.

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. *Temp Med STM TX 1/06*

TEMP MED SHORT TERM MEDICAL INSURANCE

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 ❑ MC ❑ 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 and fees are not refundable.

		SINGLE PAY (Daily Rates Minimum of 30 , Maximum of 180)	MONTHLY PAY (Monthly Rates)
1. Applicant:		$	$
2. Spouse:		$	$
3. Per Child:	$_____ Multiply (x) by # ___ of children (Pay for a maximum of 3)	$	$
4. Subtotal:	Sum of lines 1, 2 and 3	$	$
5. Single Payment:	Multiply (x) daily rate by # ____ of Days	$	NA
6. Add Monthly Administration Fee:		$12.50	$12.50
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 IAC STM License Request Form with your 1st application.

_____
Agent's Full Name

_____/_____
Social Security / Tax ID # IAC #

_____
Address

_____
City State Zip

_____/_____
Phone # Fax #

_____
Email

_____/_____
GA Name IAC#

_____
Address City State Zip

_____/_____/_____
Phone # Fax # Email

For Home Office: IAC00000000

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 toll free to: 1-888-FAX-HPA1 (329-4721)