



**SECURE 12x3 STM
(Florida)**

**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 F.

A. Coverage Effective Date:

Day after US Post Office Date Stamp
 Later Effective Date: _____

B. Coverage Length:

Single Payment for 12 Months Monthly pay for 12 Months

C. Coinsurance:

80/20 of \$10,000 50/50 of \$10,000

D. Deductible:

\$500 \$1,000 \$2,500 \$5,000

E. Payment Method:

Check or Money Order
 Credit Card (MasterCard, Visa or Discover)
 Monthly Automatic Bank Withdrawal

F. Supplement Accident Rider: Yes No

SSL-STM-1104-APP-FL

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. 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 (not applicable to DC residents) alcohol abuse or chemical dependency?..... Yes No
5. Within the past 5 years, has any person proposed for coverage tested positive for exposure to the HIV infection, or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) caused by the HIV infection or other sickness or condition derived from such infection?..... Yes No
6. 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 6, 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.

Fraud Warning: Any person who, knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Signature of Applicant: _____ Date: _____

Signature of Spouse: _____ Date: _____

This policy is primarily governed by the laws of the District of Columbia. As a result, all of the rating laws applicable to policies filed in this state do not apply to this coverage, which may result in increases in your premium at renewal that would not be permissible under a Florida approved policy. Any purchase of individual health insurance should be considered carefully, as future medical conditions may make it impossible to qualify for another individual health policy. For information concerning individual health coverage under a Florida approved policy, consult your agent or the Florida Department of Financial Services.

