



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), 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 #

COMPLETE THE FOLLOWING PLAN CHOICES:

A. Coverage Effective Date: Day after US Post Office Date Stamp, Later Effective Date; B. Coverage Length: Single Payment, Monthly Payment; C. Coinsurance; D. Deductible; E. Optional Benefits; F. Payment Method

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.

- 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:

Table with 3 columns of medical conditions: heart disorder, emphysema or COPD, degenerative disc disease, stroke, diabetes, rheumatoid or psoriatic arthritis, cancer, liver disorder, degenerative joint disease, tumor, kidney disorder, alcohol abuse, hemophilia

- 7. Have you or any person proposed for coverage been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex, or received treatment from a member of the medical profession for AIDS or ARC?
8. Has any person proposed for coverage not been a legal resident of the United States for the last 12 consecutive months?
9. If you, your spouse or any dependent combine this Policy with all prior short term policies, will it exceed 12 months of uninterrupted coverage with this carrier?

NOTE: IF "YES" IS ANSWERED ON ANY QUESTION 1 THROUGH 9, COVERAGE CANNOT BE ISSUED.

- 1. I agree that coverage will not become effective for any person whose medical history changes prior to coverage approval...
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.
3. I understand that the broker who solicited this application was acting as an independent contractor...
4. I have read this application and have verified that all of the information provided in it is complete, true and correct...
5. All information provided will be held in strictest confidence.
6. All statements and descriptions in the application for insurance are deemed to be representations and not warranties.
7. I understand that this short term policy does not count as creditable coverage toward any individual health insurance issued to me after this policy ends.

Signature of Applicant: Date: Signature of Spouse: Date:

Fraud Warning: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company.



SECURE SHORT TERM MEDICAL INSURANCE (Maine)

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

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

ABOUT THE OPTIONAL MAINE COVERAGE'S*:

If the primary Covered Person selects these coverage's and the required additional premiums are paid, the following coverage's will apply during the Coverage Period.

Serious Mental Illness -The Coinsurance Percentage for the medically necessary and appropriate treatment and diagnosis of the following mental illnesses: Schizophrenia; Bipolar disorder; Pervasive developmental disorder, or autism; Paranoia; Panic disorder; Obsessive-compulsive disorder; or Major depressive disorder.

Home Health Care - Covered Expenses will include those listed below of a home health care provider for home health care services up to 4 consecutive hours in a 24-hour period of home health care service are considered as one home health care visit and not to exceed the maximums below:

Maximum Benefit Amount: \$40 per 8-hour shift
Maximum Benefit Period: 40 shifts per Coverage Period

Charges for home health care, (up to the Maximum Benefit Amount shown above) up to a maximum of 90 visits in any 12 consecutive month period for: Part-time or intermittent home nursing care by or under the direction of a graduate registered Nurse; Home Health Aide services that are Medically Necessary as part of the Home Health Care Plan; physical, respiratory, occupational, or speech therapy and Nutrition counseling.

Domestic Partner - Your Spouse will include a Domestic Partner. Your Domestic Partner must have signed an affidavit attesting that You and Your Domestic Partner have met the Domestic Partner definition and show documentation of joint ownership or occupancy of real property, such as a joint deed, joint mortgage or a joint lease, or the existence of a joint credit card, joint bank account or powers of attorney in which each Domestic Partner is authorized to act for the other.

Coverage for Your Domestic Partner will terminate upon notification that the Domestic Partner relationship has terminated. You may not enroll another individual as a Domestic Partner until 12 months after the termination of coverage for a prior Domestic Partner.

* This is a brief outline of Maine's Optional Coverage, please review the Amendatory Endorsement Optional Benefit form

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: _____ Company Name: _____

HPA #: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____ Email: _____

GA Name: _____ HPA #: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____ Email: _____

MGA Name: _____ HPA #: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____ Email: _____

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. Optional Domestic Partner Benefit: (Maine residents)	Add \$.17 (cents) per day per policy for Single Pay Add \$5.10 per policy per month for Monthly Pay	\$
6. Optional Serious Mental Illness and Home Health Care benefit: (Maine residents)	Add \$.55 (cents) per person to be insured per day for Single Pay; Add \$16.50 per person to be insured per month for Monthly Pay	\$
7. Single Payment Method:	Multiply (x) daily rate by # ____ of Days (Minimum of 30 days)	\$
8. Add Monthly Administration Fee:		\$15.00
9. Add Enrollment Fee:	(This is paid once per application.)	\$10.00
10. Final Total:	\$	\$

Make personal check or money order payable to:

Health Plan Administrators, Inc.

Mail your application and initial payment to :

Insurance Services of America 1757 E. Baseline Rd. Ste #126 Gilbert AZ 85233

Save time and postage, if you pay by credit card, fax both sides of the

application to: 1-480-821-9297