



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. Optional Coverages

- Child Immunization Coverage Accept Reject Anesthesia for Dental Care Accept Reject

F. Payment Method: Check or Money Order

- Credit Card Monthly Automatic Bank Withdrawal

SSL-STM-0506-APP-MS

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 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 (Mississippi)

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 \_\_\_\_\_

**About the Optional Mississippi Coverages**

The Primary covered person must accept these coverage's and pay the required additional premium.

**Child Immunization Coverage:**

The Company will pay for vaccinations for Covered Dependent children from birth through 24 months of age for immunization against measles, mumps, rubella, poliomyelitis, hepatitis B, varicella, diphtheria, pertussis, tetanus, haemophilus influenza type B, and any other immunization that the Commissioner of Insurance determines to be required by law for the child.

These benefits are not subject to the Deductible, Co-payment or Co-insurance.

**Anesthesia for Dental Care Coverage:**

Benefits are payable for Covered Expenses incurred for anesthesia and for associated facility charges when the mental or physical condition of an Insured Dependent child or mentally handicapped adult requires dental treatment to be rendered under Physician-supervised general anesthesia in a Hospital setting, surgical center or dental office. These benefits are subject to the Deductible, Co-payment and Co-insurance.

**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)	\$	\$
3a. <b>Optional Child Immunization Coverage:</b> (Mississippi residents) Add \$.35 (cents) per child per day for Single Pay Add \$10.50 per child per month for Monthly Pay	\$	\$
3b. <b>Optional Anesthesia for Dental Care Coverage:</b> (Mississippi residents): Add \$.10 (cents) per child per day for Single Pay Add \$3.00 per child per month for Monthly Pay	\$	\$
4. Subtotal:                                      Add lines 1, 2, 3, 3a and 3b	\$	\$
5. Single Payment Method:                      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. <b>Final Total:</b>	\$	\$

**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 # \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ Email \_\_\_\_\_

**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**