



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's 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. 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?
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 listing medical conditions: heart disorder, stroke, cancer, tumor; emphysema or COPD, diabetes, liver disorder, kidney disorder; degenerative disc disease, rheumatoid or psoriatic arthritis, degenerative joint disease, 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 any other immune system disorder?
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...
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. My personal health information is protected at all times...

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, 2008 through June 30, 2008

How to Calculate Your Rates

There are three Secure STM rate tables for each Coverage Effective Date Rate charts of 1/1/08 through 6/30/08:

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 or name-brand drugs at over 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 CARE/INGTON 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.*

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:
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

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 1/1/08 through 6/30/08 for the 80% Coinsurance Option. This plan is available in other states. Please call Insurance Services of America at 1-800-647-4589 for rates effective 7/1/08 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 _____			
HPA # _____			
Address _____	City _____	State _____	Zip _____
Phone # _____	Fax # _____	Email _____	
GA Name _____		HPA # _____	
Address _____	City _____	State _____	Zip _____
Phone # _____	Fax # _____	Email _____	
MGA Name _____	HPA Code # _____	Phone # _____	
Address _____	City _____	State _____	Zip _____

**The \$5,000 deductible for Single Pay and Monthly Pay Up to 6 Months is available online at www.hpa-inc.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 Insurance Services of America at 1-800-647-4589 for rates effective 7/1/08.

*** 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.