



SECURE STM (Nevada)

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 (SSN #), Occupation, Telephone, Street Address, City, State, Zip, Billing Address, 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, B. Coverage Length, C. Coinsurance, D. Deductible, E. Payment Method, SSL-ISTM-0506-APP-NV

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 other than stones, 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?
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 and not as an agent of the Insurance Company.
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.

I understand that this coverage will not pay benefits for a disease or physical condition that I now have or have had within 6 months 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.

Signature of Premium Payer Date

See reverse side for rates and calculation instructions. SSL Secure STM App and Rates NV 1-08 rev. 11-6-07



**Secure STM Rates (Nevada)**

Underwritten by Standard Security Life Insurance Company of New York  
**80% of \$5,000 Co-insurance Rates for Effective Dates January 1, 2008 - June 30, 2008**

		Single Pay			Monthly Pay*			Single Pay			Monthly Pay*		
		Daily Rates			1 to 6 Months			Daily Rates			1 to 6 Months		
		<b>\$2,500 Deductible</b>						<b>\$1,000 Deductible</b>					
Age/Area	SEX	F	G	H	F	G	H	F	G	H	F	G	H
2-19	M	1.56	1.64	1.73	60.68	64.03	67.79	2.16	2.28	2.42	85.27	90.17	95.68
20-24	M	1.79	1.88	1.99	69.98	73.92	78.34	2.49	2.63	2.79	98.56	104.30	110.75
25-29	M	1.64	1.73	1.83	64.00	67.56	71.56	2.29	2.42	2.57	90.59	95.82	101.71
30-34	M	2.20	2.31	2.43	84.13	88.48	93.38	2.97	3.12	3.30	115.37	121.69	128.80
35-39	M	2.53	2.65	2.80	97.42	102.61	108.45	3.44	3.63	3.84	134.64	142.18	150.66
40-44	M	2.94	3.09	3.26	114.04	120.28	127.30	4.06	4.29	4.54	159.90	169.03	179.30
45-49	M	3.61	3.80	4.02	141.29	149.25	158.20	5.03	5.31	5.63	199.12	210.72	223.77
50-54	M	4.47	4.72	5.00	176.52	186.69	198.14	6.32	6.69	7.10	251.63	266.54	283.31
55-59	M	5.71	6.04	6.41	227.04	240.39	255.42	8.12	8.60	9.14	324.75	344.26	366.21
60-64	M	7.12	7.54	8.01	284.20	301.16	320.24	10.19	10.80	11.49	409.16	433.99	461.92
2-19	F	1.79	1.88	1.99	69.98	73.92	78.34	2.49	2.63	2.79	98.56	104.30	110.75
20-24	F	2.02	2.13	2.25	79.29	83.81	88.90	2.85	3.01	3.20	113.19	119.84	127.33
25-29	F	1.90	2.00	2.12	74.63	78.86	83.62	2.65	2.80	2.97	105.21	111.36	118.29
30-34	F	2.40	2.52	2.65	92.10	96.96	102.43	3.29	3.47	3.67	128.66	135.82	143.88
35-39	F	2.66	2.79	2.95	102.74	108.27	114.48	3.67	3.87	4.10	143.95	152.07	161.21
40-44	F	3.12	3.28	3.47	121.35	128.05	135.59	4.32	4.57	4.84	170.54	180.34	191.36
45-49	F	3.62	3.82	4.04	141.96	149.95	158.95	5.06	5.35	5.67	200.45	212.13	225.27
50-54	F	4.46	4.70	4.98	175.86	185.99	197.39	6.29	6.65	7.06	250.30	265.12	281.80
55-59	F	5.34	5.64	5.99	211.75	224.14	238.09	7.56	8.01	8.51	302.15	320.24	340.58
60-64	F	6.34	6.70	7.12	252.30	267.24	284.06	9.02	9.55	10.16	361.30	383.12	407.66
Per Child		1.09	1.14	1.21	42.22	44.57	47.21	1.49	1.58	1.67	58.84	62.23	66.05
		<b>\$500 Deductible</b>						<b>\$250 Deductible</b>					
Age/Area	SEX	F	G	H	F	G	H	F	G	H	F	G	H
2-19	M	2.93	3.10	3.29	116.51	123.38	131.10	4.55	4.82	5.12	182.31	193.33	205.71
20-24	M	3.39	3.59	3.81	135.12	143.16	152.20	5.27	5.58	5.94	211.56	224.41	238.88
25-29	M	3.11	3.29	3.49	123.82	131.15	139.39	4.84	5.13	5.46	194.28	206.04	219.28
30-34	M	3.97	4.18	4.43	155.91	164.79	174.78	6.06	6.41	6.80	241.00	255.23	271.25
35-39	M	4.65	4.91	5.21	183.83	194.47	206.43	7.15	7.57	8.04	285.53	302.57	321.74
40-44	M	5.50	5.82	6.17	218.40	231.21	245.62	8.53	9.03	9.60	341.36	361.92	385.05
45-49	M	6.89	7.29	7.75	274.89	291.27	309.68	10.72	11.36	12.08	430.43	456.60	486.04
50-54	M	8.67	9.19	9.77	347.35	368.28	391.83	13.59	14.42	15.34	547.42	580.96	618.69
55-59	M	11.21	11.88	12.64	450.37	477.80	508.65	17.63	18.71	19.92	711.60	755.48	804.84
60-64	M	14.13	14.99	15.96	569.35	604.27	643.56	22.32	23.69	25.24	902.36	958.26	1021.15
2-19	F	3.42	3.62	3.85	136.45	144.57	153.71	5.32	5.64	6.00	213.55	226.53	241.14
20-24	F	3.91	4.14	4.40	156.39	165.77	176.32	6.10	6.47	6.88	245.46	260.45	277.31
25-29	F	3.63	3.85	4.09	145.09	153.76	163.51	5.66	6.00	6.38	227.51	241.37	256.96
30-34	F	4.42	4.67	4.95	174.53	184.58	195.88	6.79	7.19	7.64	270.91	287.03	305.16
35-39	F	4.95	5.23	5.54	195.80	207.19	220.00	7.64	8.09	8.60	305.47	323.77	344.35
40-44	F	5.86	6.20	6.58	233.02	246.75	262.20	9.15	9.69	10.30	366.62	388.77	413.69
45-49	F	6.92	7.33	7.78	276.22	292.68	311.19	10.76	11.41	12.14	432.43	458.72	488.30
50-54	F	8.64	9.15	9.73	346.02	366.87	390.33	13.54	14.36	15.29	545.42	578.84	616.43
55-59	F	10.44	11.06	11.77	419.13	444.59	473.23	16.39	17.39	18.51	661.08	701.78	747.56
60-64	F	12.50	13.25	14.10	502.88	533.62	568.19	19.71	20.92	22.28	796.01	845.21	900.56
Per Child		2.03	2.15	2.28	80.77	85.55	90.92	3.16	3.35	3.56	126.64	134.30	142.92

These rates and zip areas apply to new coverage effective dates 1/1/08 through 6/30/08 for the 80% Coinsurance Option. Please call Insurance Services of America at 1-800-647-4589 for the rates effective 7/1/08.

The \$5,000 deductible and 50% Coinsurance Option rates are available online. Standard Security Life Insurance Company reserves the right to decline applications received using outdated rates and zip code areas.

\*The monthly rates listed include the following Communicating for America (CA) STM Enhancement Series fees: \$5 per dependent child; \$7.50 per person in age bands 2-29; and \$15 per person in age bands 30-64.

Communicating for America (CA) STM Enhancement Series is not an insurance benefit, nor is it affiliated with Standard Security Life Ins. Co. of New York or a part of the STM insurance plan.

\*\* 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.

**How to Calculate Your Rates**

There are two 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

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.

**Nevada Zip Area Rate Classifications**

Zip Prefix	Area Letter
889, 893, 896-897	F
894-895, 898	G
890-891	H

**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.

**About the STM Enhancement Series**

Included with your coverage is Communicating for America\*\* (CA) Healthy Lifestyle Advocates, which provides discounts for the following services and or purchases: • Vitamins, herbs and nutritional supplements – 10-30% off already low prices • Nurse-on-call access to a registered nurse 24 hours a day, seven days a week • Chiropractic services – 10%-30% off at more than 28,000 private chiropractors and alternative health services • Prescription drugs – up to 15-60% off on generic or name-brand drugs at over 45,000 pharmacies nationwide • Vision eyewear care - up to 15%-45% off eyeglasses, contact lenses and non-prescription sunglasses through a network of more than 40,000 retail optical locations, including Pearle Vision, Target Optical, Sears Optical and LensCrafters • Dental services – 20%-60% on dental expenses from 34,000 dentists in CAREINGTON International.

\*\*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 is a part of the STM insurance plan. CA provides access to discount services administered by CAREINGTON International. Enhancement series benefits may vary by state.

**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