



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 E.

A. Coverage Effective Date:

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

B. Coverage Length:

Single Pay (Minimum of 30 days, maximum of 180 days)
 Enter # ___ Days
 Monthly Pay - up to 6 months

C. Coinsurance: 80/20 of \$5,000 50/50 of \$5,000

D. Deductible:

\$250 \$500 \$1,000 \$2,500

E. Payment Method:

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

SSL-STM-1104-APP-CO

"The policy does not provide portability of prior coverage. As a result, any injury, sickness, or pregnancy for which you have incurred charges, received medical treatment, consulted a health care professional, or taken prescription drugs within 12 months of the effective date of the policy will not be covered under the policy."

Eligibility For Coverage: Have you or any other person to be insured been covered under two or more nonrenewable Short-Term policies during the past 12 months? If "yes", then the policy cannot be issued. You must wait 6 months from the date of your last such policy to apply for a Short-Term policy.

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.

- Will there be any other health insurance in force on the policy date?..... Yes No
- Is the proposed insured, spouse, or any dependent child now pregnant?..... Yes No
- Is any proposed insured currently eligible for Medicaid?..... Yes No
- Has any person proposed for coverage been declined for health insurance in the past 12 months? (Missouri residents do not have to answer)..... Yes No
- 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
- 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 Yes No
- 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 7, 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.

Signature of Applicant: _____ Date: _____

Signature of Spouse: _____ Date: _____

Fraud Warning: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

