



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 _____
E-mail address _____

COMPLETE 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 _____

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-ISTM-1104-APP-LA

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.

- 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. Is any proposed insured currently eligible for Medicaid?
4. Has any person proposed for coverage been declined for health insurance in the past 12 months?
5. 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 alcohol abuse or chemical dependency?
6. 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
7. 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 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 by the insurer and understand that if the coverage applied for becomes effective, I agree to all terms of the 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: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice: Genetic information, receipt of genetic services or refusal to submit to a genetic test may not be used to terminate, cancel, limit, non-renew or deny coverage or establish differentials in premiums.

