SECURE STM (Maine)

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 ______________________________

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, E and F.

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**
- ❑ **Monthly Pay - 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. Payment Method:

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

F. Optional Benefits:

- ❑ Serious Mental Illness and Home Health Care
- ❑ Domestic Partner

SSL-ISTM-1105-APP-ME

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?........ ❑Yes ❑No
2. Is the proposed insured, spouse, or any dependent child now pregnant?........ ❑Yes ❑No
3. Is any proposed insured currently eligible for Medicaid?........ ❑Yes ❑No
4. Has any person proposed for coverage been declined for health insurance in the past 12 months?........ ❑Yes ❑No
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?........ ❑Yes ❑No
6. Have you or any person proposed for coverage been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex, or received treatment from a member of the medical profession for AIDS or ARC? Answer this question "no" if you have tested positive for HIV but have not developed symptoms of the disease AIDS………… ❑Yes ❑No
7. Has any person proposed for coverage not been a legal resident of the United States for the last 12 consecutive months? ❑Yes ❑No
8. If you, your spouse or any dependent combine this Policy with all prior short term policies, will it exceed 12 months of uninterrupted coverage? ❑Yes ❑No

NOTE: IF "YES" IS ANSWERED ON ANY QUESTION 1 THROUGH 8, COVERAGE CANNOT BE ISSUED.

Do you intend to lapse or otherwise terminate existing health insurance and replace it with this policy issued by the insurer? ❑Yes ❑No

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. I understand that the authorization to release medical information excludes disclosure of the result of a test for HIV if the applicant has tested positive for HIV but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS.
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 short term policy does not count as creditable coverage toward any individual health insurance issued to me after this policy ends. I acknowledge that this means that continuity rights may be lost, and I may not be able to limit the effect of preexisting condition exclusions in an individual policy.

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 a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

The Credit Card / Automatic Bank Withdrawal request forms and rate calculation instructions are on the reverse side. *(SECURE STM ME 1/06)*

SECURE SHORT TERM MEDICAL INSURANCE (Maine)

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 ❑ MC ❑ 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 MAINE COVERAGE'S*:

If the primary Covered Person selects these coverage's and the required additional premiums are paid, the following coverage's will apply during the Coverage Period.

Serious Mental Illness -The Coinsurance Percentage for the medically necessary and appropriate treatment and diagnosis of the following mental illnesses: Schizophrenia; Bipolar disorder; Pervasive developmental disorder, or autism; Paranoia; Panic disorder; Obsessive-compulsive disorder; or Major depressive disorder.

Home Health Care - Covered Expenses will include those listed below of a home health care provider for home health care services up to 4 consecutive hours in a 24-hour period of home health care service are considered as one home health care visit and not to exceed the maximums below:

- Maximum Benefit Amount: $40 per 8-hour shift
- Maximum Benefit Period: 40 shifts per Coverage Period

Charges for home health care, (up to the Maximum Benefit Amount shown above) up to a maximum of 90 visits in any 12 consecutive month period for: Part-time or intermittent home nursing care by or under the direction of a graduate registered Nurse; Home Health Aide services that are Medically Necessary as part of the Home Health Care Plan; physical, respiratory, occupational, or speech therapy and Nutrition counseling.

Domestic Partner - Your Spouse will include a Domestic Partner. Your Domestic Partner must have signed an affidavit attesting that You and Your Domestic Partner have met the Domestic Partner definition and show documentation of joint ownership or occupancy of real property, such as a joint deed, joint mortgage or a joint lease, or the existence of a joint credit card, joint bank account or powers of attorney in which each Domestic Partner is authorized to act for the other.

Coverage for Your Domestic Partner will terminate upon notification that the Domestic Partner relationship has terminated. You may not enroll another individual as a Domestic Partner until 12 months after the termination of coverage for a prior Domestic Partner.

** This is a brief outline of Maine's Optional Coverage, please review the Amendatory Endorsement Optional Benefit form SSL-IAE-1104-ME for more details.*

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:____________________ Company Name:____________________

SS# / Tax ID # ____________________ HPA #____________________

Address: ____________________ City:____________ State:______ Zip:______

Phone #: ____________ Fax #: ____________ Email: ____________

GA Name: ____________________ HPA #:____________________

Address: ____________________ City:____________ State:______ Zip:______

Phone #: ____________ Fax #: ____________ Email: ____________

MGA Name: ____________________ HPA #:____________________

Address: ____________________ City:____________ State:______ Zip:______

Phone #: ____________ Fax #: ____________ Email: ____________

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)
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. Optional Domestic Partner Benefit: (Maine residents)	**Add $.17** (cents) **per day per policy for Single Pay** **Add $5.10 per policy per month for Monthly Pay**	$	$
6. Optional Serious Mental Illness and Home Health Care benefit: (Maine residents)	**Add $.55** (cents) **per person to be insured per day for Single Pay Add $16.50 per person to be insured per month for Monthly Pay**	$	$
7. Single Payment Method:	Multiply (x) daily rate by # ____ of Days (Minimum of 30 days)	$	NA
8. Add Monthly Administration Fee:		$12.50	$12.50
9. Add One Time Enrollment Fee:		$10.00	$10.00
10. **Final Total:**		$	$

Make personal check or money order payable to:
Health Plan Administrators, Inc.
Mail your application and initial payment to :
HPA, Inc. , 15436 N. Florida Ave, Suite 105, Tampa, FL 33613

Save time and postage, if you pay by credit card, fax both sides of the application toll free to: 1-888-FAX-HPA1 (329-4721)