

Secure STM
 Secure Saver STM (Oregon)

COMPLETE THE FOLLOWING TO INSURE YOURSELF:

Applicant:
 Last Name _____
 First 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 THE FOLLOWING TO INSURE YOUR SPOUSE/DOMESTIC PARTNER AND/OR CHILDREN:

Spouse/Domestic Partner:
 Last Name _____
 First Name _____
 Date of Birth _____ Age _____ Sex _____
 Social Security Number _____
 Occupation _____
 Child(ren)Name _____
 Date of Birth _____ Age _____
 Social Security Number _____
 Child(ren)Name _____
 Date of Birth _____ Age _____
 Social Security Number _____
 Child(ren)Name _____
 Date of Birth _____ Age _____
 Social Security Number _____

COMPLETE THE FOLLOWING PLAN CHOICES:

Coverage Effective Date:
 Day after US Post Office Date Stamp
 Later Effective Date: _____
 • No more than 60 days in advance

Coverage Length:
 Single Payment: *Specify number of days of coverage*
 _____ days (*minimum 30 days, maximum 180 days*) or
 Monthly Payment:
 Up to 6 Months

Plan Selection:
 Secure STM
Coinsurance:
 80/20 of \$10,000
 50/50 of \$10,000
Deductible:
 \$500 \$1,000
 \$2,500 \$5,000

Secure Saver STM
Daily Deductible
 \$250 \$500
 \$750 \$1,000

Method of Payment
 Check or Money Order
 Credit Card
 Monthly Automatic Bank Withdrawal

ANSWER THE FOLLOWING MEDICAL HISTORY QUESTIONS:

Misstatements and omissions may be a material misrepresentation and a basis for rescission of coverage. In the event of rescission; (1) coverage will be void as of the Effective Date; (2) all premiums paid will be refunded; (3) all claims that have been submitted will be denied; (4) if any claims have been paid, the amount of claims paid will be deducted from any premium refund due.

1. Will there be any other group or individual major medical health insurance in force on the policy effective date? Yes No
2. Are you or any person applying for coverage now pregnant? Yes No
3. Have you or any person applying for coverage been declined for health insurance for a condition that is still present?... .. Yes No
4. Are you or any person applying for coverage currently eligible for Medicaid? Yes No
5. Are you or any person applying for coverage currently over 300 pounds if male or over 250 pounds if female? Yes No
6. Within the past 5 years have you or any person applying for coverage been aware of, been diagnosed with, been treated by or received follow-up care with a member of the medical profession, taken medication for or had a device surgically implanted or in place for:

<input type="checkbox"/> heart disorder, heart attack, coronary artery disease, coronary bypass or stent <input type="checkbox"/> peripheral vascular disease or carotid artery disease <input type="checkbox"/> stroke or other neurological disorder <input type="checkbox"/> cancer or tumor	<input type="checkbox"/> paraplegia, quadriplegia or multiple sclerosis <input type="checkbox"/> stem cell transplant <input type="checkbox"/> emphysema or COPD (chronic obstructive pulmonary disease) <input type="checkbox"/> diabetes <input type="checkbox"/> liver disorder	<input type="checkbox"/> kidney disorder other than stones <input type="checkbox"/> degenerative disc disease or herniated disc <input type="checkbox"/> rheumatoid or psoriatic arthritis <input type="checkbox"/> degenerative joint disease of the knees or hips <input type="checkbox"/> alcohol or drug abuse or dependency <input type="checkbox"/> hemophilia
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7. Have you or any person applying for coverage been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex, or any other immune system disorder within the last 10 years immediately prior to the date of this application? Answer this question "no" if you have tested positive for HIV but have not developed symptoms of the disease AIDS Yes No

(NOTE: IF "YES" IS ANSWERED ON ANY QUESTION 1 THROUGH 7, COVERAGE CANNOT BE ISSUED.)

ACCEPTANCE AND ACKNOWLEDGEMENT:

- A. I agree that coverage will not become effective for any person whose medical history changes prior to the persons Effective Date, 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.
- B. I hereby request coverage under the policy issued to the group policyholder. I agree to all terms of the group policy if the coverage applied for becomes effective.
- C. I understand that the agent or broker who solicited this application and upon whose explanation of benefits, limitations or exclusions we relied (1) was acting as an independent contractor and not as an agent of the Insurance Company; (2) was retained by me as my agent; and (3) has no right to alter the application, bind or approve coverage or alter any of the terms or conditions of the policy.
- D. I certify that (1) I have read this application; (2) all of my (our) answers are within my (our) personal knowledge; and (3) all of my (our) answers are complete, true and correct.
- E. I agree to immediately notify the insurer of any changes in any of the information contained in this application which may occur prior to the Effective Date of coverage.
- F. I understand that health insurance benefits are excluded for pre-existing conditions and 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.
- G. I understand that cancellation of this coverage within the 10 Day Right to Return the Certificate provision as stated in the Certificate of Insurance will result in a refund of premiums only. Any administrative fees or other fees that may apply will not be refunded.
- H. I understand that this is short term health insurance coverage (the duration of which does not exceed six months and cannot be renewed)

Signature of Applicant or (Legal Guardian): _____ **Date:** _____

Signature of Spouse/Domestic Partner: _____ **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 penalty.

If you selected payment by credit card or monthly bank draft, please complete the applicable request form below:

CREDIT CARD PAYMENT REQUEST:

I authorize IHC Health Solutions 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 Accountholder's 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 IHC Health Solutions 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

STM RATE CALCULATION INSTRUCTIONS:		SINGLE PAY (Daily Rates Minimum of 30, Maximum of 180)	MONTHLY PAY (Monthly Rates)	FOR AGENT USE ONLY: Include a current copy of your license and the completed IHC License Request Form with your 1st application.
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.				Agent's Full Name _____ IHC # _____
1. Applicant:		\$ _____	\$ _____	Address _____
2. Spouse:		\$ _____	\$ _____	City _____ State _____ ZIP _____
3. Child:	Multiply (x) by # ____ of children (Pay for a maximum of 3)	\$ _____	\$ _____	Phone _____ Fax _____ E-mail _____
4. Subtotal:	Add lines 1, 2 and 3	\$ _____	\$ _____	GA Name _____ IHC # _____
5. Single Payment Option:	Multiply (x) daily rate by # ____ of days (Minimum of 30 days)	\$ _____	NA	Address _____
6. Add Monthly Administration Fee:		\$15.00	\$15.00	City _____ State _____ ZIP _____
7. Add Association Dues:	(This is paid once per year.)	\$10.00	\$10.00	Phone _____ Fax _____ E-mail _____
8. Final Total:		\$ _____	\$ _____	MGA Name _____ IHC# _____
				Address _____
				City _____ State _____ ZIP _____
				Phone _____ Fax _____ E-mail _____

**Make personal check or money order payable to:
IHC Health Solutions
Save time and postage; if you pay by credit card or ACH, fax both sides of the application to: 1-888-329-4721**

**Mail your application and initial payment to :
IHC, P.O. Box 15250 Loves Park, IL 61132-5250**

www.hpainsurance.com