STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK
SHORT TERM MEDICAL INSURANCE APPLICATION

Secure STM
Secure Saver STM - MISSOURI

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 AND/OR CHILDREN:

Spouse:
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
☐ Up to 12 Months (May not be available in all states)

Plan Selection:
☐ **Secure STM**
Coinsurance:
☐ 80/20 of $10,000
☐ 50/50 of $10,000
Deductible:
☐ $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. Is the proposed insured, spouse, or any dependent child now pregnant? .... ☐ Yes ☐ No
3. Are you or any person applying for coverage currently eligible for Medicaid? .... ☐ Yes ☐ No
4. Are you or any person applying for coverage currently over 300 pounds if male or over 250 pounds if female? .... ☐ Yes ☐ No
5. Within the past 5 years have you or any person applying for coverage been aware of, received an abnormal test report for, 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:

■ heart disorder, heart attack, coronary artery disease, coronary bypass or stent ■ peripheral vascular disease or carotid artery disease ■ stroke or other neurological disorder ■ cancer or tumor	■ paraplegia, quadriplegia or multiple sclerosis ■ stem cell transplant ■ emphysema or COPD (chronic obstructive pulmonary disease) ■ diabetes ■ liver disorder	■ kidney disorder other than stones ■ degenerative disc disease or herniated disc ■ rheumatoid or psoriatic arthritis ■ degenerative joint disease of the knees or hips ■ alcohol or drug abuse or dependency ■ hemophilia

.... ☐ 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 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

(NOTE: IF "YES" IS ANSWERED ON ANY QUESTION 1 THROUGH 6, COVERAGE CANNOT BE ISSUED.)

ACCEPTANCE AND ACKNOWLEDGEMENT:

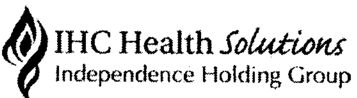
A. I agree that coverage will not become effective for any person whose medical history changes prior to the persons Effective Date, such that the person's answer would be "yes" to any of the Medical History questions in this application. If such person is the Applicant, coverage is automatically declined 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.

Signature of Applicant or (Legal Guardian): .... **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 penalty.

Ins-Special, Inc
7505 State Hwy 37 / PO Box 218
Purdy MO 65734
800-789-0182
www.insspecial.com



SECURE SHORT-TERM AND SECURE SAVER MEDICAL INSURANCE
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 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: 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. Single Payment Option:	Multiply (x) daily rate by # ____ of days (Minimum of 30 days)	$	NA
6. Add Monthly Administration Fee:		**$15.00**	**$15.00**
7. Add Association Dues:	(This is paid once per year.)	**$10.00**	**$10.00**
8. **Final Total:**		$	$

FOR AGENT USE ONLY:
Include a current copy of your license and the completed IHC License Request Form with your 1st application.

Agent's Full Name ______________ IHC # ______________
Address ______________
City ______________ State ______________ ZIP ______________
Phone ___/___ Fax ___/___ E-mail ______________

GA Name ______________ IHC # ______________
Address ______________
City ______________ State ______________ ZIP ______________
Phone ___/___ Fax ___/___ E-mail ______________

MGA Name ______________ IHC# ______________
Address ______________
City ______________ State ______________ ZIP ______________
Phone ___/___ Fax ___/___ E-mail ______________

Make personal check or money order payable to:
IHC Health Solutions

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

Save time and postage; if you pay by credit card or ACH, fax both sides of the application to: 1-888-329-4721

SECURE STM Cal. Chart 12-09

Ins-Special, Inc
7505 State Hwy 37 / PO Box 218
Purdy MO 65734
800-789-0182
www.insspecial.com