Secure STM
Secure Saver STM

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

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 364 days (may not be available in all states)

Plan Selection:
Secure STM
Coinsurance:
□ 80/20 of $10,000
□ 80/20 of $15,000
□ 80/20 of $20,000
□ 70/30 of $10,000
□ 70/30 of $15,000
□ 70/30 of $20,000
□ 50/50 of $10,000
□ 50/50 of $15,000
□ 50/50 of $20,000

Deductible:
□ $1,000 □ $2,500
□ $5,000

Secure Saver STM
Daily Deductible:

□ $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. 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, 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

7. 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 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.

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.

Arkansas Residents: 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.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Kentucky, Ohio and Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

New Mexico Residents: 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 civil fines and criminal penalties.

Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

IHC Health Solutions
Independence Holding Group

SECURE SHORT TERM MEDICAL INSURANCE

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

Send completed application to:
IHC Health Solutions
P.O. Box 15250, Loves Park, IL 61132-5250

If you selected payment by credit card or monthly bank draft, please complete the applicable section 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 first month and each month thereafter for the Monthly Pay Option.

❑ VISA ❑ MASTERCARD ❑ 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 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 Enrollment Fee:	(This is paid once per coverage period.)	$10.00	$10.00
8.	Add Association Dues:	Single Pay: Multiply $0.09 by # ____ of days (Minimum of 30 days)		$2.50
9.	**Final Total:**		$	$

FOR AGENT USE ONLY:

Include a current copy of your license and the completed IHC Health Solutions License Request Form with your first application.

DRS Insurance
Agent's Full Name

____
IHC Health Solutions Agent Number

____
Address

____
City State ZIP

_______________ _______________
Phone Number Fax Number

____
Email

Black, Gould & Associates 591800000
General Agent Name IHC Health Solutions Agent Number

____
Address City State ZIP

_______________ _______________ _______________
Phone Number Fax Number Email