HCC Life Insurance Company
Short Term Medical Insurance Application

For use in Indiana

Please submit completed enrollment forms with payment to:

Insurance Services of America
1757 E. Baseline Road, Suite 126
Gilbert, AZ 85233

- Please complete this enrollment form entirely. Failure to provide complete information may delay processing.
- You may elect the $5,000 and $7,500 deductible options by applying online or contacting us.

Personal Details Please provide the following details for all individuals to be covered.

Name (First and Last)	Date of Birth	Gender	Contact Information		
Primary		□ Male □ Female	Address		
Spouse		□ Male □ Female	City	State	Zip
Child 1		□ Male □ Female	Phone Number		
Child 2		□ Male □ Female	E-mail Address		

Plan Options Please check the boxes corresponding to your elections for a policy period deductible and coinsurance.

Deductible □ $250 □ $500 □ $1,000 □ $2,500

Coinsurance □ 80% of $5,000 □ 50% of $5,000

Requested Effective Date _____ / _____ / _____

Payment Option □ Monthly – 6 month plan

□ Single Up Front (please specify end date)
Specify End Date _____
Number of days (max 180)_____

Eligibility Questions Please answer the questions below as they apply to all family members applying for coverage.

1. Will any applicant have other health insurance in force on the policy effective date or be eligible for Medicaid?	□ Yes □ No
2. Are you or any applicant: a. Now pregnant, an expectant father, in process of adoption, or undergoing infertility treatment? b. Over 300 pounds if male or over 250 pounds if female?	□ Yes □ No
3. Within the last 5 years has any applicant been diagnosed, treated, or taken medication for any of the following: cancer or tumor, stroke, heart disease including heart attack, chest pain or had heart surgery, COPD (chronic obstructive pulmonary disease) or emphysema, Crohn's disease, liver disorder, degenerative disc disease or herniation/bulge, rheumatoid arthritis, kidney disorder, diabetes, degenerative joint disease of the knee, alcohol abuse or chemical dependency, or any neurological disorder?	□ Yes □ No
4. Within the last 5 years has any applicant been diagnosed or treated by a physician or medical practitioner for Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV)? Residents of WI do not need to disclose HIV test results.	□ Yes □ No
5. If you are not a US Citizen, do you expect to legally reside in the US for the duration of the policy?	□ Yes □ No □ US citizen

If you have answered "Yes" to questions 1 through 4 or "No" to question 5 above, coverage cannot be issued. Thank you for your interest.

For product information or assistance with this enrollment form, please contact:

Insurance Services of America
1757 E. Baseline Road, Suite 126
Gilbert, AZ 85233

Toll Free Phone: 800-647-4589
Toll Free Fax: 866-793-4779

Rate Calculation	Use the rate table corresponding to your choice of plan option and coinsurance level to complete applicant rates below, then follow the calculation instructions.			
			Monthly Payments	**Single Up-front Payment**
A	Applicant's Rate		A	A
B	Spouse's Rate		B	B
C	Per child _____ x # _____ =		C	C
D	A + B + C =		D	D
E	Zip Code Factor		E	E
F	D x E = Monthly / Daily Premium Total (round to the nearest penny)		F	F
G	Number of Months/Days to be Covered		**n/a**	G
H	F x G =		**n/a**	H
I	Administrative Fee* *One-time fee is $10 if paper policy is requested. This fee is refundable if the policy is not issued, not taken after issue or is returned to us during the 30-day free examination period. No fee is collected if you choose electronic fulfillment.		I $5.00	I $5.00
J	**Total Due**	**Monthly:** F + I= **Daily:** H + I =	J	J

Payment Information

Please provide complete payment information. Enrollment forms without payment cannot be processed.

☐ Check/Money Order (Single Up-Front Payment Only)
☐ MasterCard ☐ VISA
☐ Discover ☐ American Express

Credit Card Number	Exp Date

Name on Card

Phone #

Billing Address (including city, state and zip)

Check or Money Orders should be made payable, in US dollars, to HCC Life Insurance Company. If paying by credit card, I authorize HCC Life to debit my Discover, VISA, MasterCard or American Express account for the amount specified in the Rate Calculation section. If I have selected a monthly plan, I hereby request and authorize HCC Life to debit my Credit Card account for the proper installment amounts on the due dates of the installments. This authorization will remain in effect for the duration of the Coverage Period elected or until revoked by me in writing. Coverage purchased by credit card is subject to validation and acceptance by the credit

Cardholder Signature	Date

Authorization

I hereby request coverage under a policy underwritten by HCC Life Insurance Company. I understand this insurance contains a Pre-existing Condition exclusion, a Pre-certification Penalty and other restrictions and exclusions. I agree that coverage will not become effective for me or any dependent whose medical status, prior to the effective date, has changed and therefore results in a "yes" answer to any of the medical questions on this application. If my medical status changes in this way, coverage will be declined for all individuals included on this application. I understand that if I have elected the Monthly Payment option, my credit card will be charged each month on the due date of the premium for 6 months, depending on the plan I have selected. I understand that I may terminate the scheduled payments by notifying HCC Life in writing at least one business day prior to the next scheduled payment date. I understand that this coverage is not renewable or extendable. I understand that the information contained herein is a summary of the coverage offered in the policy and that I may obtain a complete copy of the policy upon request to HCC Life. I understand that HCC Life, as underwriter of the plan, is solely liable for the coverage and benefits provided under the insurance. I understand and agree that the insurance agent/broker, if any, assisting with this application is a representative of the applicant. If signed by a representative of the applicant, the undersigned represents his/her capacity to so act. If signed as guardian or proxy of the applicant, the undersigned represents his/her capacity to so act. By acceptance of coverage and/or submission of any claim for benefits, the applicant ratifies the authority of the signer to so act and bind the applicant. Fraud Warning: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete or misleading information may be committing a crime and may be subject to civil or criminal penalties.

Applicant Signature	Date	Spouse Signature	Date

Signed by HCC Life Appointed Agent:	Plan Administrator Use Only:	
	PBC 612.110.04.12	Code: