HCC Life STM Enrollment Form

For use in OR

HCC Life Insurance Company

Please submit completed enrollment forms with payment to:

HCC Life Insurance Company
251 N. Illinois Street, Suite 600
Indianapolis, IN 46204

- 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 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 term date)

Specify Term Date _____

Number of days (max 180) _____

Medical 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? ☐ Yes ☐ No

2. Have/Are you, or any applicant: ☐ Yes ☐ No
   a. Now pregnant, in process of adoption or undergoing infertility treatment?
   b. Over 300 pounds if male or over 250 pounds if female?

3. Within the last 5 years has any applicant been diagnosed, treated, or taken medication for or experienced signs or symptoms of 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)? ☐ 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? ☐ US Citizen ☐ Yes ☐ No

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 Rd. Suite 126
Gilbert, AZ 85233
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	Monthly / Daily Association Fee		G $5.00	G $0.17
H	F + G = Total Monthly / Daily Rate		H	H
I	Number of Days to be Covered		n/a	I
J	H x I =		n/a	J
K	Administrative Fee		K $10.00	K $10.00
L	**Total Due**	**Monthly:** H + K= **Daily:** J + K =	L	L

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 card company.

Cardholder Signature	Date

Authorization

I hereby request coverage under the insurance issued to Consumer Benefits of America and 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 Enrollment Form. If my medical status changes in this way, coverage will be declined for all individuals included on this Enrollment Form. 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 Certificate of Insurance and that I may obtain a complete copy of the Certificate of Insurance 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 Enrollment Form 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. If I am not already a member of Consumer Benefits of America, I hereby request to be enrolled as a member. I will receive a membership packet after my membership fees of $5 per month are received. **Fraud Warning:** Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance Enrollment Form 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 6OR.110.07.09	Code: 23600

Coverage term may not exceed 180 days.