



# SELECT SHORT TERM MEDICAL INSURANCE APPLICATION (GENERIC)

Applicant: 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: Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
 Social Security Number \_\_\_\_\_ Occupation \_\_\_\_\_  
 Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security Number \_\_\_\_\_

### COMPLETE THE FOLLOWING CHOICES:

Coverage Effective Date:

Day after US Post Office Date Stamp  Later Effective Date: \_\_\_\_\_

Coverage Length:

1 Month  2 Months  3 Months  4 Months  5 Months  6 Months  up to 12 Months (Monthly Payments)

Coinsurance Choice:

80/20 of \$5000  50/50 of \$5000

Deductible:

\$250  \$500  \$1000  \$2500

### PAYMENT METHOD:

<input type="checkbox"/> Check or Money Order	<input type="checkbox"/> Credit Card	<input type="checkbox"/> Monthly Automatic Bank Withdrawal
<input type="checkbox"/> 1-6 Months Coverage: <input type="checkbox"/> Single Prepay <input type="checkbox"/> Monthly Payments		<input type="checkbox"/> Up To 12-Months Coverage: Monthly Payments Available Only

### ANSWER THE FOLLOWING MEDICAL HISTORY QUESTIONS:

Any material misstatement or omission of information made on this form will be considered a misrepresentation and may be the basis for later rescission of my coverage and that of my dependents. In the event of rescission or termination for any reason, the Insurer shall have the right to deduct any premium due and unpaid from any claims payable to me or my dependents.

- Will there be any other health insurance in force on the policy date?.....  Yes  No
- Is the proposed insured, spouse, or any dependent child now pregnant?.....  Yes  No
- Is any proposed insured currently eligible for Medicaid?.....  Yes  No
- Has any person proposed for coverage been declined for health insurance in the past 12 months?  
(Missouri residents do not have to answer).....  Yes  No
- Within the past 5 years have you been aware of, diagnosed, treated by a member of the medical profession, or taken medication for cancer or tumor, stroke, heart disease including heart attack, chest pain or had heart surgery, COPD (chronic obstructive pulmonary disease) or emphysema, liver disorder, degenerative disc disease or herniation/bulge, rheumatoid arthritis, degenerative joint disease of the knee, insulin-dependant diabetes (not applicable to DC residents), alcohol abuse or chemical dependency?.....  Yes  No
- Have you been diagnosed or treated for 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
- Has any person proposed for coverage not been a legal resident of the United States for the last 12 consecutive months?....  Yes  No

### NOTE: IF "YES" IS ANSWERED ON ANY QUESTION 1 THROUGH 8, COVERAGE CANNOT BE ISSUED.

- I agree that coverage will not become effective for any person whose medical history changes prior to coverage approval, 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.
- I hereby request coverage under the policy issued to the group policyholder by the insurer and understand that if the coverage applied for becomes effective, I agree to all terms of the group policy. I understand that health insurance benefits are excluded for pre-existing conditions.
- I hereby authorize any hospital, clinic, physician, surgeon, practitioner or insurance company to furnish the Insurer or its representative with any and all information concerning any sickness or injury I or my dependents may have suffered, including copies of all hospital or medical records. A copy of this authorization shall be considered as valid as the original and remains in effect for 2 years from the date of my signature.
- I understand that the broker who solicited this application was acting as an independent contractor and not as an agent of Fairmont Premier Insurance Company/Fairmont Specialty Insurance Company. I further acknowledge that the person who solicited this application and upon whose explanation of benefits, limitations or exclusions we relied, was retained by me as my agent, and that such person has no right to bind or approve coverage or alter any of the terms or conditions of the policy.
- I have read this application and have verified that all of the information provided in it is complete, true and correct, and is all within my personal knowledge. I agree to immediately notify the insurer of any changes in any of the information contained in this form which may occur prior to the approval of coverage.

I understand that this coverage will not pay benefits for a disease or physical condition that I now have or have had in the past.

Signature of Applicant: \_\_\_\_\_ 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 penalties.

AHU27286

See side 1 for rates, calculation instructions, Credit Card and Automatic Bank Withdrawal authorization forms.



**Select STM  
(Generic)**

**UNITED CONSUMERS SAVINGS ASSOCIATION  
ENROLLMENT REQUEST**

The UCSA provides members with money saving discounts. Upon completion of this form and payment of the association dues, I understand that I will be entitled to UCSA's benefits. Please enroll me in the UCSA. Enclosed is my \$10 association dues for this enrollment.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

The UCSA is not affiliated with Fairmont Premier Insurance Company / Fairmont Specialty Insurance Company, nor is it a part of the insurance plan.

**UCSA DISCOUNT PLUS CARD  
ENROLLMENT REQUEST**

The UCSA Discount Plus Card provides discounts for: Retail cost of prescription drugs; Dental services; Eye and vision care; Chiropractic services; Vitamin & Nutritional supplements; 24 Hour Nurse Help Line; Accudiet.com, an on-line interactive exercise and diet program; National Health Survey, discounts for Health & Lifestyle Assessment. The UCSA Discount Plus Card fulfillment kit is mailed to you automatically after you've enrolled and paid your monthly fee. The UCSA Discount Plus Card fees are \$3 per dependent child, \$5 per person in age bands 2 through 29 and \$10 per person in age bands 30 through 64 years old. If you are purchasing the STM insurance, the fees are included with your monthly rates.

I hereby accept the UCSA Discount Plus Card. I agree to pay the fees as described above.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

The UCSA Discount Plus Card is not affiliated with Fairmont Premier Insurance Company / Fairmont Specialty Insurance Company, nor is it a part of the insurance plan.

**AUTOMATIC CHECK WITHDRAWAL REQUEST**

Selecting the automatic bank withdrawal option for your Select STM monthly premium payments, they will automatically be withdrawn from your checking account. Complete the form below and include a voided check with the Enrollment Form and the initial premium.

Financial Institution's name: \_\_\_\_\_

Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I request that you pay and charge my account debits drawn from my account by Health Plan Administrators, Inc. 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 and to Health Plan Administrators, Inc. 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 \_\_\_\_\_

**CREDIT CARD PAYMENT REQUEST**

Indicate type of card:  VISA  MC  Discover

List Digits of Account: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_

I authorize Health Plan Administrators, Inc. to charge the above credit card for the premium and fees listed according to the payment mode selected.

Authorizing Signature \_\_\_\_\_ Date \_\_\_\_\_

**SELECT STM RATE CALCULATION CHART**

(Underwritten by Fairmont Premier / Fairmont Specialty Ins. Co.)

Effective January 1, 2006

	<u>SINGLE PAY</u> <u>2 - 6 MONTHS</u>	<u>MONTHLY PAY</u> <u>OR ONE MONTH</u>
1. Applicant Rate:	\$ _____	\$ _____
2. Spouse Rate:	\$ _____	\$ _____
3. Per Child \$ ____ X # ____ of children (Max. 3):	\$ _____	\$ _____
4. Subtotal:	\$ _____	\$ _____
5. Multiply by # of mos. ____: (Single Payment)	\$ _____	NA
6. Add Administration fee:	NA	\$ 12.50
7. Add Administration fee	\$ 25.00	NA
8. Subtotal:	\$ _____	\$ _____
9. Add Association Dues:	\$ 10.00	\$ 10.00
10. Total Amount:	\$ _____	\$ _____

Note: Premiums are not refundable after the 30 day free look period.

SAVE TIME AND POSTAGE IF YOU PAY BY CREDIT CARD. SIMPLY FAX BOTH SIDES OF THE APPLICATION FORM TOLL FREE TO: 1-888-FAX HPA1 (329-4721)

MAKE YOUR PERSONAL CHECK OR MONEY ORDER PAYABLE AND MAIL TO:

HEALTH PLAN ADMINISTRATORS, INC.  
15436 N. FLORIDA AVE., STE. 105  
TAMPA, FL 33613

**DEPENDENT CHILD COVERAGE**

Your dependent children must be unmarried, under age 19 (or under age 25 and a full time student) and have a social security number. List all of your eligible dependent children to be insured on the application for insurance. You only pay for a maximum of up to three dependent children, regardless of the number of eligible dependent children to be insured.

**CHILD ONLY COVERAGE**

The minimum age is 2 years old for child(ren) coverage without an adult guardian also insured. Use the 2-24 rate for either the male or female, based on the gender of the oldest child; then use the per child rate for each of the other siblings to be insured. The parent or legal guardian must sign and date the application. You only pay for a maximum of up to three dependent children, regardless of the number of eligible dependent children to be insured.

**AGENT USE ONLY**

AGENT NAME: \_\_\_\_\_  
HPA # \_\_\_\_\_ SS#: \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_  
PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_  
EMAIL: \_\_\_\_\_  
GA: \_\_\_\_\_  
PHONE: \_\_\_\_\_ CODE #: \_\_\_\_\_  
MGA: \_\_\_\_\_  
PHONE: \_\_\_\_\_ CODE #: \_\_\_\_\_

See side 2 for the Select Short Term Medical Application for Insurance.