

# PERSONAL HEALTH PLANS BENEFIT SELECTION FORM

## *SIMPLE SOLUTIONS FOR INDIVIDUALS & FAMILIES*

*Underwritten by Standard Security Life Insurance Company of New York*

CASE NUMBER

APPLICANT NAME

SOCIAL SECURITY NUMBER

(LAST)

(FIRST)

(INITIAL)

**PLAN SELECTION:** Design your plan by selecting your In-Network plan options. Out-of-network benefits differ from In-Network benefits and are based on your selections below. See the product brochure for details.

<input type="checkbox"/> <b>Deluxe Plan</b>  <u>Deductible</u> <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$4,500 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$5,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$25,000  <u>Coinsurance</u> <input type="checkbox"/> 80% <input type="checkbox"/> 70% <input type="checkbox"/> 50%  <u>Physician Office Visit</u> <input type="checkbox"/> \$40 Copay <input type="checkbox"/> Deductible & Coinsurance  <u>Out-of-Pocket Maximum</u> <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$6,000 <input type="checkbox"/> \$10,000  <u>Premium Saving Options</u> <input type="checkbox"/> \$20,000 Outpatient Services Calendar Year Maximum  <input type="checkbox"/> \$250 Outpatient Surgical Services Copay  <input type="checkbox"/> \$500 Inpatient Confinement Copay  <input type="checkbox"/> \$100,000 Calendar-Year Maximum	<input type="checkbox"/> <b>Advantage Plan</b>  <u>Deductible</u> <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$25,000  <u>Physician Office Visit</u> <input type="checkbox"/> \$40 Copay <input type="checkbox"/> Deductible & Coinsurance	<input type="checkbox"/> <b>Value Plan</b>  <u>Deductible</u> <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$4,500 <input type="checkbox"/> \$5,500 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$25,000	<input type="checkbox"/> <b>High Deductible Health Plan</b>  <u>Deductible</u> Single    Family <input type="checkbox"/> \$1,800 <input type="checkbox"/> \$3,600 <input type="checkbox"/> \$2,700 <input type="checkbox"/> \$5,450 <input type="checkbox"/> \$3,500* <input type="checkbox"/> \$7,000* <input type="checkbox"/> \$5,250* <input type="checkbox"/> \$10,500* *Available only if 100% Coinsurance Option is selected.  <u>Coinsurance Options</u> <input type="checkbox"/> 100% <input type="checkbox"/> 80%  <u>HSA Options</u> <input type="checkbox"/> IHC AHV HSA <input type="checkbox"/> Own HSA (Submit HSA Attestation form)	<input type="checkbox"/> <b>Copay Plan</b>  <u>Deductible</u> <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000  <u>Inpatient and Surgical Services Out-of-Pocket Maximum</u> <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$8,000	<input type="checkbox"/> <b>Premier Plan</b>  <u>Daily Deductible</u> <input type="checkbox"/> \$500 <input type="checkbox"/> \$1000  <u>Physician Office Visit</u> <input type="checkbox"/> \$40 Copay <input type="checkbox"/> Deductible & Coinsurance  <u>Out-of-Pocket Maximum</u> <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$8,000
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Preferred Provider Organization (PPO) Network Selected:

Optional Benefits	
Outpatient Prescription Drug Coverage (Discount Drugs Only is not an insurance benefit)	<input type="checkbox"/> 1) Discount Drugs Only <input type="checkbox"/> 2) Deductible & Coinsurance – <i>Available only on the High Deductible Health Plan</i> <input type="checkbox"/> 3) \$30 Copay Generic / Discount Drugs Only on Formulary, Non-Formulary & Specialty Drugs <input type="checkbox"/> 4) \$30 Copay Generic / Deductible & Coinsurance on Formulary, Non-Formulary & Specialty Drugs – <i>Not Available on Premier Plan</i> <input type="checkbox"/> 5) \$30 Copay Generic / \$500 Rx Deductible then \$50 Copay Formulary, \$75 Copay Non-Formulary, \$100 Copay Specialty Drugs <input type="checkbox"/> 6) \$30 Copay Generic / \$1000 Rx Deductible then \$50 Copay Formulary, \$75 Copay Non-Formulary, \$100 Copay Specialty Drugs <i>Note: Rx Plans 3, 4, 5, 6 are not available on the High Deductible Health Plan</i>
18-Month Initial Rate Guarantee	<input type="checkbox"/> Yes <input type="checkbox"/> No (12-Month Initial Rate Guarantee will apply if not elected)
Wellness/Preventive Care Coverage	<input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> None
Supplemental Accident	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> None
Health Empowerment Package	<input type="checkbox"/> Yes <input type="checkbox"/> No ( <i>This is not a health insurance benefit</i> )

Attach this form to the *Standard Security Life Insurance Company Application for Insurance*

For Administrative Use Only							
Case Number	Enter	Date	Approved By	Date	Eff Date	PCEFDT	Other:
_____	_____	_____	_____	_____	_____	_____	_____

# STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

CASE NUMBER: \_\_\_\_\_

## APPLICATION FOR INSURANCE

*Underwritten by Standard Security Life Insurance Company of New York*ATTENTION PRODUCER: Where do you want the Policy mailed? (Check one):  Producer  Insured

### GENERAL INFORMATION

Applicant Information (Please print in blue or black ink)

Applicant's Name			Social Security Number			
Last	First	Initial				
Applicant's Home Address (P.O. Box Not Acceptable)						
Street Address		City	State	Zip Code		
Billing Address				E-MAIL ADDRESS		
Street		City	State	Zip Code		
Home Telephone Number	Work Telephone Number	State of Birth		Best Time and Place to Call		
				<input type="checkbox"/> Home <input type="checkbox"/> Work Time: _____		
Occupation (Title & Industry)		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate	Age	Height Ft In	Weight Lbs
		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married				

### Dependent Information (Complete only for dependents to be covered under this plan)

Spouse's Name				Social Security Number			
Last	First	Initial					
Spouse's Occupation (Title & Industry)		State of Birth	Height Ft In	Weight Lbs	Birthdate	Age	
Dependent(s) Name (First and Last)		Relationship	Sex	Birthdate	Height Ft In	Weight Lbs	Full-time Student? Yes or No

Has the Applicant or Spouse (if applying for coverage) used tobacco or tobacco cessation products during the past 12 months?

Applicant:  No  Yes – indicate types of tobacco/cessation products and the frequency of usage: \_\_\_\_\_Spouse:  No  Yes – indicate types of tobacco/cessation products and the frequency of usage: \_\_\_\_\_

### Requested Effective Date (check one)

 I request the Company assign my effective date to be the 1<sup>st</sup> of the month following approval. I request an effective date of \_\_\_\_\_ (must be the 1<sup>st</sup> or 15<sup>th</sup> of the month).

If the Company is unable to approve the application within 60 days of the application date, the requested effective date will not be honored and a new, currently dated application may be required.

Mode of Payment: Direct Bill: Select  Monthly  Quarterly or  Semi-annually **Submit check for first premium payment with this application.**  
Monthly Automatic Payment: Select  Credit Card  Bank Draft Complete the Monthly Automatic Payment Plan page.

### Other Health Insurance In force or Pending (*must be completed for primary and dependent applicants*)

 Yes  No If yes, please provide the following information:

Carrier Name: \_\_\_\_\_ Policy No. \_\_\_\_\_ Effec. Date: \_\_\_\_\_ Termination Date: \_\_\_\_\_

Is this an employer-sponsored group health plan?  Yes  NoIs it your intent to be considered under HIPAA provisions?  Yes  No If yes, you must complete the HIPAA eligibility section of this application.

**EVIDENCE OF INSURABILITY**

<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Excluding MO residents: Has any person to be insured ever been declined, postponed, rideder, or rated up for medical, disability, or life insurance with another insurance carrier? If yes, please indicate the action and explain: 1. MO residents: Has any person to be insured ever been postponed, rideder, or rated up for medical, disability, or life insurance with another insurance carrier? If yes, please indicate the action and explain:
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Is any person to be insured receiving treatment, taking medication, or been advised of a condition that will require medical attention or to have medical test(s)? If yes, list names and provide details in the Health History section on the following page.
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Has any person to be insured received or are currently receiving disability benefits? If yes, list names and type of coverage:
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Has any person to be insured ever been diagnosed or tested positive for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex by a Physician or member of the medical profession? If yes, list names:
<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Has anyone to be insured had breast implants, pin, plate, or other implants? If yes, list names and provide details on the following page.
<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Has any person to be insured had any convictions for reckless driving or driving under the influence of alcohol or drugs? If yes, list name, violation(s) and date(s) of occurrence in the Health History section on the following page.
<input type="checkbox"/> Yes <input type="checkbox"/> No	7. In the past 5 years, has any person to be insured engaged in, or plan to engage in, any hazardous sport including, but not limited to: scuba diving, rodeo activities, skydiving or auto, motorcycle or motor boat racing? If yes, please explain on the following page.
<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Is any person to be insured now pregnant, an expectant parent, or in the process of adopting a child, or in the process of utilizing a surrogate birth mother, whether applying for coverage or not? If yes, list names and provide details in the Health History section on the following page.
<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Is any person to be insured currently taking or have you been prescribed medications within the past 12 months? List details/medications on the following page.
<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Has any person to be insured previously applied for a policy administered by Insurers Administrative Corporation? If yes, list the policy number: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Has any person to be insured been hospitalized within the last 7 years? If yes, list names and provide details on the following page.

12. Within the past 5 years, has any person to be insured had any symptoms, diagnosis, consultation, treatment, or taken any medication or received counseling for:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Abnormal Test Results			Eye Disorders			Neurological Disease		
Alcoholism/Alcohol Abuse			Fractures/Dislocations			Pap Smear, Abnormal		
Allergies			Gallbladder Disorder			Paralysis		
Arthritis or Rheumatism			Headaches/Migraine			Prostate/Rectal Disorder		
Asthma/Respiratory Disorder			Heart Disorder/Murmur/Heart Attack/Coronary Artery Disease			Reproductive Organs Disorder/Endometriosis		
Back/Muscle or Joint Disorder			Hepatitis: A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>			Sexually Transmitted Diseases		
Bladder Disorder			Hernia			Sinus Disorder		
Blood Disorder/Hemophilia			High Blood Pressure/Hypertension			Skin Disorder		
Bone Disease/Deformity			High Cholesterol			Sleep Disorders		
Breast Disorder/Fibrocystic Breast Disease			Infertility Testing/Treatment			Spinal Disorder/Back/Neck Strain		
Cancer			Kidney Disorder			Stroke		
Colitis, Spastic Colon, Polyps			Liver Disorder			Thyroid or Goiter		
Congenital Disorder			Lupus/Systemic or Discoid			Transplants		
Cystic Fibrosis			Lymphadenopathy/Immune Disorder			Tuberculosis		
Diabetes/Pancreatic Disorders			Menstrual Disorder			Tumors/Cysts/Polyps/Growths		
Digestive Disorder/Reflux			Mental, Nervous, Emotional Disorder / Anxiety/Depression/Attention Deficit Disorder			Ulcerative Colitis/Crohn's/Regional Ileitis		
Drug Addiction			Mental Retardation			Ulcers		
Ear/Throat Disorders			Down's Syndrome			Urinary Tract Disorder		
Eating Disorder/Anorexia/ Bulimia			Muscular Dystrophy			Vascular Disorder		
Emphysema/Lung Disorder/COPD			Cerebral Palsy			Other conditions		
Epilepsy and/or Seizure			Brain or Nerve Disorder					

*If you answered "Yes" to any of the above conditions, list the condition and provide details in the Health History section on the following page.*

**HEALTH HISTORY**

**INSTRUCTIONS:** Provide complete details to any question marked "Yes" in the Evidence of Insurability section in the space provided below. We may need to request additional information regarding your or any of your dependents' health history from you or your dependents' attending physician. If you need more space, please use the Health History Supplementary Form located at the end of this application.

Question #	Person's Name	Condition(s) & Treatment	Date of Onset and Last Office Visit Mo./Yr.	Recovery Date Mo./Yr.	Complete Names and Addresses of Physicians & Hospitals

**LAST PHYSICIAN SEEN**

**INSTRUCTIONS:** List the name of the last medical care provider you visited and the condition that was treated.

Physician's Name	Address	Condition(s) & Treatment	Phone	Dates visited

**MEDICATIONS CURRENTLY PRESCRIBED OR BEING USED**

**INSTRUCTIONS:** List all medications prescribed or taken by you or your dependents currently and in the past 12 months.

Person's Name	Medications	Frequency & Dosage	Length of time on medication	Date medication was last taken	Complete Names and Addresses of Physicians

**HIPAA ELIGIBILITY:** If applying for HIPAA coverage, complete this section and provide a copy of your Certificate of Creditable Coverage.

<b>INSTRUCTIONS:</b> This section must be completed if anyone applying for coverage is electing coverage under HIPAA provisions. If you reside in a state that offers coverage under a risk pool arrangement, please ask your producer about your risk pool coverage options.				
Who is applying for HIPAA eligibility? What will the effective date of coverage be?		<input type="checkbox"/> Applicant	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)
Has anyone applying for HIPAA coverage been continuously covered by health insurance (the last of which is a group health plan) for a minimum of eighteen months?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
What was the reason the coverage terminated under the most recent health insurance plan?	Was it for non-payment of premium? Was it for fraud?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Was there a break in health insurance coverage in excess of 62 days during the past 18 months?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is any HIPAA applicant eligible for or currently have group health insurance through an employer, spouse's employer or is a dependent on any person's plan?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is any HIPAA applicant eligible for coverage under any of the following: COBRA, State Continuation, Federal Employee's Continuation, MEDICARE or MEDICAID?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was the most recent coverage under COBRA or any State or Federal Continuation plan? a. If "yes," when did coverage begin _____ and when will coverage be exhausted under such plan _____?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was the current coverage a conversion plan elected through a previous carrier?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**AGREEMENT & SIGNATURE**

**INSTRUCTIONS:** Read the following information and signify your agreement with the terms of this agreement for insurance by signing and dating the application as indicated below.

**Premium Payment:** I agree that (1) I am responsible for making the proper monthly premium payments; (2) a grace period of 31 days is allowed for any premium due after the first premium and if such premium is not paid before the expiration of the 31-day grace period, coverage for all insured persons shall lapse as of the premium due date; (3) any negotiable premium checks received in an envelope postmarked after the 31 day grace period will be refunded less any amounts due (if any) from previous months; (4) negotiation of any check from or on behalf of the insured shall not constitute acceptance of premium as premium is only accepted when acknowledged and applied by insurer. There is a one-time application fee.

**Pre-certification and Signature:** I agree that failure to pre-certify treatment results in reduced benefits pursuant to the terms of the policy.

**U.S. Resident:** I understand that the coverage under this plan is available to United States residents only, benefits are not payable for medical expenses outside of the United States except when traveling, and if I stay outside the United States for more than 90 days I will be deemed to be residing outside of the United States and not traveling.

**Application for insurance** I understand that I am applying as an individual with Standard Security Life Insurance Company of New York I understand that my application is subject to medical underwriting and approval by Standard Security Life Insurance Company of New York or its authorized administrator in accordance with the underwriting guidelines in effect. I understand that this coverage is not an employer health plan and I certify that (a) premiums are being paid by me as a personal expense and, neither my employer nor the employer of my dependents is now or in the future will be paying any part of the premium either directly or through wage adjustments or otherwise and (b) to the best of my knowledge and belief my employer has not and will not maintain, endorse or represent this health plan as an employer health insurance plan for any purpose, including a tax deduction, individuals not meeting this certification above are not eligible for this plan. I further understand that acceptance of the check submitted with this application does not constitute approval or guarantee of coverage.

**Updated Information:** I agree to immediately notify Standard Security Life Insurance Company of New York or its authorized administrator if there is any change in my health or the health of my dependents that would require a change in the answers provided in this application prior to being notified of the approval of this coverage.

**My answers are true, complete and correct:** I have personally reviewed all of my answers to the questions on this application and any attachments to it and certify that all of the information I have provided is true, complete and correct, I agree that it is my responsibility to provide truthful, complete and correct information. I certify I fully understand the questions asked. I agree that any misstatements or failure to report information may be used as the basis of rescission or reformation of coverage for me or my dependents, if any. I agree that under no circumstances is any agent allowed to: (a) waive, alter or modify any questions; (b) permit me to inaccurately answer any question; or (c) instruct me not to disclose any particular medical condition on the application. I agree that no agent is authorized or has the authority to alter the terms of the Policy.

**Fraud Statement:** Any person who with intent to defraud or knowing that he/she is facilitating a fraudulent act against an insurer, submits and application or files a claim containing any false or deceptive statement, may be guilty of insurance fraud as determined by a court of law.

**Attachments:** I understand that any attachments to this application become a part of it.

**Other Agreements:** I have reviewed and understand the policy's benefits, limitations, and exclusions, including the pre-existing condition limitation provision. I understand that the major medical health insurance coverage for each applicant, if issued, will be subject to a pre-existing condition limitation for up to 2 years, unless the medical condition is disclosed in the Evidence of Insurability and Health History sections of this application and not specifically excluded by name from coverage under the Policy.

**DO NOT CANCEL ANY EXISTING HEALTH INSURANCE UNTIL RECEIVING WRITTEN NOTICE OF APPROVAL.**

Dated at \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ on the \_\_\_\_\_ day of \_\_\_\_\_ Month \_\_\_\_\_, 20\_\_\_\_ Year \_\_\_\_\_.

\_\_\_\_\_  
Name of Applicant or parent, if applicant is under age 18 (print)

\_\_\_\_\_  
Name of Spouse if applying for coverage (print)

\_\_\_\_\_  
Signature of Applicant (or parent, if applicant is under age 18) \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Spouse (if applying for coverage) \_\_\_\_\_ Date \_\_\_\_\_

**MONTHLY AUTOMATIC PAYMENT PLAN – Complete All Applicable Areas**

To initiate the Automatic Payment Plan, the following must accompany your application:

- This fully completed and signed form.
- Credit Card information; - **OR** -
- A voided check OR savings account deposit slip (business accounts not acceptable)

*Coverage purchased by check is subject to clearance of the check, and coverage purchased by credit card is subject to acceptance of the credit card issuer.*

Standard Security Life Insurance Company of New York (SSL), or its designated administrators, is hereby authorized to debit my bank account or credit card for the SSL insurance premiums for the initial amount, if applicable, and for each month thereafter until this Authorization is terminated. **I understand that the applicable initial premiums collected will be refunded to me if my health insurance Policy is not issued.** I agree that the named institution shall be fully protected in honoring any such payments. The institution's rights and treatment of each payment shall be the same as if it were signed by me. If any such payment is dishonored, whether with or without cause, I understand that the institution shall not be liable whatsoever, even though such dishonor results in a forfeiture of insurance. This Authorization will remain in effect until the bank is notified of termination by me in writing. To terminate insurance coverage, I will also notify SSL or its administrators in writing.

**Credit Card Payment** Choose one:  MasterCard  Visa

Initial Amount collected upon receipt of application \$ \_\_\_\_\_

Name (as it appears on card) \_\_\_\_\_

Card# \_\_\_\_\_ Exp. Date \_\_\_\_\_

Signature of Cardholder \_\_\_\_\_ Date \_\_\_\_\_

**Monthly Bank Account Bank Draft**

Initial Amount collected upon receipt of application \$ \_\_\_\_\_

Name of Bank \_\_\_\_\_ Address \_\_\_\_\_

Routing No. \_\_\_\_\_ Account No. \_\_\_\_\_

Signature of Cardholder or Depositor \_\_\_\_\_ Date \_\_\_\_\_

Name (please print) \_\_\_\_\_

Relationship to Proposed Insured \_\_\_\_\_

**PRODUCER / GENERAL AGENT INFORMATION**

Producer's Name \_\_\_\_\_ Company Name \_\_\_\_\_

IHC Producer # \_\_\_\_\_ Are you licensed in the state where the application was completed?  Yes  No

Are you currently appointed with SSL in the state where the application was completed?

Yes  No (If not, please refer to the Producers Guide for contracting rules.)

Address \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Business Phone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_ E-Mail Address \_\_\_\_\_

**PRODUCER'S STATEMENT:** I certify that I have truly and accurately recorded all the information given to me by the applicant and I know of no other medical information about those persons applying for coverage other than that contained on this application. I understand that commissions cannot be paid unless appointed with Standard Security Life Insurance Company of New York

Producer's Signature \_\_\_\_\_ Date \_\_\_\_\_ Date Application Sent to General Agent \_\_\_\_\_

**General Agent's Name:** \_\_\_\_\_ General Agent's IHC # \_\_\_\_\_

General Agent's Phone (\_\_\_\_) \_\_\_\_\_ General Agent's Fax (\_\_\_\_) \_\_\_\_\_ General Agent's E-Mail \_\_\_\_\_

\_\_\_\_\_ Date Application Received by General Agent \_\_\_\_\_ Date Application Sent to IHC \_\_\_\_\_

**PRODUCER'S FINAL CHECKLIST**

- ✓ Are all the questions answered and boxes checked?
- ✓ Has the applicant (and spouse, if applying) signed the Agreement & Signature section on the application?
- ✓ Has the applicant enclosed a personal check for the initial premium payable to IHC Health Solutions (not required for Monthly Bank Drafts or Credit Card payments)?

Submit to IHC Underwriting; 1173 W. Main St. Ste E; Whitewater, WI 53190; Fax 866-570-5234; Phone 866-472-6555

**Authorization for Release of Health-Related Information.**

I authorize the disclosure of health information regarding, or related to the following individuals for whom an application for insurance has been submitted:

Print Name(s): (Last)	(First)	(MI)	Date of Birth (Month/Day/Year)	Social Security Number
1.				
2.				
3.				
4.				
5.				
6.				
7.				

I authorize the disclosure of any and all information that: (i) is created or received by a health care provider, health plan including health insurer or health insurance agent, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (ii) relates to the past, present, or future physical or mental health or condition of an individual listed above; the provision of health care to an individual listed above; or the past, present, or future payment for the provision of health care to an individual listed above. This authorization permits the disclosure of all medical records including without limitation those containing information relating to diagnoses, treatments, consultation, care, advice, laboratory or diagnostic tests, physical examinations, recommendations for future care, and prescription drug information.

I specifically authorize the disclosure of information related to (i) communicable diseases, including HIV, AIDS or AIDS related complex (to the extent permitted by both state and federal law); (ii) drug and alcohol abuse and treatment; (iii) mental illness and treatment; and (iv) genetic conditions including genetic testing (to the extent permitted by both state and federal law). Notwithstanding the above, this authorization does not authorize the release of psychotherapy notes.

I authorize any and all health care providers including without limitation physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, pharmacy benefit managers, pharmacies or pharmacy-related facilities; and any and all health plans, insurance companies, insurance support organizations (such as MIB Group), business associates of health plans or insurance companies and those persons or entities providing services to such business associates to disclose the information described above.

I authorize Standard Security Life Insurance Company of New York ("SSL"), including its affiliated companies, subsidiaries and business associates, including those persons or entities providing services to its business associates, to receive the disclosure of information authorized herein and use the information disclosed pursuant to this authorization.

The purpose of the disclosure authorized herein is to permit SSL, including its affiliated companies, subsidiaries and business associates, including those persons or entities providing services to its business associates, to obtain and use the information described above to make prospective and retrospective eligibility, underwriting and risk rating determinations, including whether the individual is subject to a pre-existing condition exclusion.

This authorization shall expire twenty-four (24) months after the date on which it is executed below.

I understand that eligibility for the health plan is conditioned on my execution of this authorization for the use or disclosure of the information described above for the purpose of making eligibility, underwriting and risk rating determinations. Except as otherwise stated herein, treatment, payment, enrollment in a health plan, or eligibility for benefits is not conditioned on an authorization for the use or disclosure of the information described above.

I understand that I may revoke this authorization by sending written notice of my intent to revoke this authorization to P.O. Box 37587, Phoenix, AZ 85069, Attention Privacy Officer.

I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

A copy or facsimile of this authorization shall be as valid as the original.

Signature of each Individual over the age of 18 or the Individual's Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_  
X \_\_\_\_\_  
X \_\_\_\_\_  
X \_\_\_\_\_

If signed by the individual's legal representative (e.g. a parent on behalf of a child), please describe the representative's authority to sign on behalf of the individual:

Name: \_\_\_\_\_ Authority: \_\_\_\_\_

**STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK**

**MIB GROUP, INC. (MIB) PRE-NOTIFICATION**

**To Proposed Insured:** Information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB Group, Inc., a **not for profit** membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may, upon request, supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02181-8734; and telephone number is: 866-692-6901 (TTY 866-346-3642 for hearing impaired).

**I acknowledge receipt of the MIB Group, Inc. (MIB) Pre-Notification which described how information is obtained and used by Standard Security Life Insurance Company of New York.**

\_\_\_\_\_  
Signature of Proposed Insured (if age 18 or over)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Spouse (if applying for coverage)

\_\_\_\_\_  
Date