# Enrolling is Simple.
# Just Follow These 3 Easy Steps…

## Step 1

**COMPLETE THE APPLICATION IN BLUE OR BLACK INK.** Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: fax:

## Step 2

**SEND THE COMPLETED APPLICATION TO:**

**Please make your check payable to:** HCC Life Insurance Company

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

**If you have questions please contact our office at:**

# HCC Life Insurance Company
# Short Term Medical Insurance Application
**For use in TX**

**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 Single Payment option for 6 to 11 months and 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
Monthly – 11 month plan
Single Payment (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.

| Question | Answer |
|---|---|
| 1. Will any applicant have other health insurance in force on the policy effective date or be eligible for Medicaid? Texas residents are not required to answer this question. | Yes No |
| 2. Are you or any applicant:<br>a. Now pregnant, an expectant father, in process of adoption, or undergoing infertility treatment?<br>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 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, 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 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 2 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:**

| **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* *Fee is $5 on each monthly payment after the first payment. | 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 card company.

| 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-authorization 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 or 11 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: |