



# Amigo Short Term Medical Plan Enrollment Form

For use in CA



(Herein referred to as HCC Life)

Please submit completed applications with payment to:

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

- Please complete this application 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		<input type="checkbox"/> Male <input type="checkbox"/> Female	Address		
Spouse		<input type="checkbox"/> Male <input type="checkbox"/> Female	City	State	Zip
Child 1		<input type="checkbox"/> Male <input type="checkbox"/> Female	Phone Number		
Child 2		<input type="checkbox"/> Male <input type="checkbox"/> Female	E-mail Address		

<b>Plan Options</b>	Please check the boxes corresponding to your elections for deductible and coinsurance.		<b>Payment Option</b>	<input type="checkbox"/> Monthly – 6 month plan
	<b>Deductible</b>	<input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500		<input type="checkbox"/> Single Up Front (please specify term date)
	<b>Coinsurance</b>	<input type="checkbox"/> 80% of \$5,000 <input type="checkbox"/> 50% of \$5,000		Specify Term Date _____
	<b>Requested Effective Date</b>	____/____/____		Number of days (max 180) _____

**Medical Questions** Please answer the questions below as they apply to the Applicant (Primary person listed above) applying for coverage. For each family member applying for coverage, complete and answer the questions on the Dependent Medical Questionnaire.

1. Will you have other health insurance in force on the policy effective date or be eligible for Medicaid?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you:	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. Been denied insurance due to any health reasons for a condition that is still present?	
b. Now pregnant, in process of adoption or undergoing infertility treatment?	
c. Over 300 pounds if male or over 250 pounds if female?	
3. Within the last 5 years have you 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Within the last 5 years have you been diagnosed or treated by a physician or medical practitioner for Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. If you are not a US Citizen, do you expect to legally reside in the US for the duration of the policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> US citizen
<p><b>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.</b></p> <p><b>California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.</b></p>	

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

Kenneth M. Clemens  
URL, Inc.  
5320 Jaycee Ave.  
Harrisburg, PA  
Phone: 717-540-5690  
Fax: 717-540-5628  
E-mail: kenc@urlfinancial.com

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 Months / Days to be Covered	n/a	I
J	H x I =	n/a	J
K	Administrative Fee	K \$10.00	K \$10.00
L	<b>Total Due</b> Monthly: H + K = Daily: J + K =	L	L

Payment Information	
Please provide complete payment information. Applications without payment cannot be processed.	
<input type="checkbox"/> <b>Check/Money Order</b> (Single Up-Front Payment Only) <input type="checkbox"/> <b>MasterCard</b> <input type="checkbox"/> <b>VISA</b> <input type="checkbox"/> <b>Discover</b> <input type="checkbox"/> <b>American Express</b>	
Credit Card Number	Exp Date
Name on Card	
Phone #	
Billing Address (including city, state and zip)	
<p>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.</p>	
Cardholder Signature	Date

Authorization			
<p>I hereby request coverage under the insurance issued to the Consumer Benefits of America Association 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 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 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 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. If I am not already a member of the Consumer Benefits of America Association, 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 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.</p>			
Applicant Signature	Date	Spouse Signature	Date
Signed by HCC Life Appointed Agent:		Plan Administrator Use Only:	23713-0001
		PBC 6CA.110.01.09	Code:



**Amigo Short Term Medical Plan  
Dependent Medical Questionnaire  
For use in CA**



Please complete this application entirely. Failure to provide complete information may delay processing.

Name (First and Last)	
<b>Primary Applicant Name:</b>	
<b>Dependent Name:</b>	
<b>Dependent Date of Birth:</b>	

Medical Questions      Please answer the questions below as they apply to the dependent named above.	
1. Will the dependent have other health insurance in force on the policy effective date or be eligible for Medicaid?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has the dependent: a. Been denied insurance due to any health reasons for a condition that is still? b. Now pregnant, in process of adoption or undergoing infertility treatment? c. Over 300 pounds if male or over 250 pounds if female?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Within the last 5 years has the dependent 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Within the last 5 years has the dependent been diagnosed or treated by a physician or medical practitioner for Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. If the dependent is not a US Citizen, does he/she expect to legally reside in the US for the duration of the policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> US citizen
<b>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. California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.</b>	

Authorization			
I hereby request coverage under the insurance issued to the Consumer Benefits of America Association 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 application. If my medical status changes in this way, coverage will be declined for all individuals included on this application. 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 6CA.111.01.09	Code: