



Amigo Short Term Medical Plan Application For use in ME



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 Single Payment option for 6 to 12 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		<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

Plan Options	Please check the boxes corresponding to your elections for deductible and coinsurance.	Payment Option
Deductible	<input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500	<input type="checkbox"/> Monthly – 6 month plan <input type="checkbox"/> Monthly – 12 month plan <input type="checkbox"/> Single Up Front (please specify termination) Specify Term Date _____ Number of days (max 180) _____
Coinsurance	<input type="checkbox"/> 80% of \$5,000 <input type="checkbox"/> 50% of \$5,000	
Requested Effective Date	____ / ____ / ____	

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 or be eligible for Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have/Are you, or any applicant: <input type="checkbox"/> Yes <input type="checkbox"/> No a. Been denied insurance due to any health reasons for a condition that is still present (Does not apply to residents of MO)? 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 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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)? Answer this question 'NO' if you have tested positive for HIV but have not developed either symptoms or the disease 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
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 application, 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	Number of Months / Days to be Covered	n/a	G
H	F x G =	n/a	H
I	Administrative Fee	I \$12.00	I \$12.00
J	Total Due Monthly: F + I = Daily: H + I =	J	J

Payment Information	
Please provide complete payment information. Applications without payment cannot be processed.	
<input type="checkbox"/> Check/Money Order (Single Up-Front Payment Only) <input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> Discover <input type="checkbox"/> 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-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 or 12 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. All statements and descriptions made by any individual in this application are considered representations and not warranties. Warning: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.			
Applicant Signature	Date	Spouse Signature	Date
Signed by HCC Life Appointed Agent:		Plan Administrator Use Only:	
		PBC 6ME.110.01.09	Code: 23713-0001

HAVE YOU OR ANY OTHER PERSON TO BE INSURED BEEN COVERED UNDER A NONRENEWABLE SHORT-TERM POLICY DURING THE PAST TWELVE MONTHS? YES NO
IF "YES," FOR HOW LONG? _____. THIS NEW COVERAGE COMBINED WITH ANY PRIOR SUCCESSIVE SHORT TERM COVERAGE CANNOT EXCEED 12 MONTHS.

No alteration may be made in this Application by any person other than the Applicant without the written consent of the Applicant.



**Amigo Short Term Medical Plan
Application Addendum
For use in ME**

NO RECOVERY FOR PRE-EXISTING CONDITIONS: No benefits will be provided during the term of the policy for Pre-Existing Conditions.

This Policy provides coverage for a short term duration only. It is not renewable.

Coverage under the short term medical policy does not count as creditable coverage toward any individual health insurance. This means coverage under the policy will be treated as a break in coverage. You will not be able to limit or apply the coverage towards any pre-existing condition waiting period in any individual policy that is issued after coverage under the policy ends. Coverage under the short term medical policy will count as creditable coverage for group health insurance issued after the policy ends.