

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 plan options. Non-Preferred Provider benefits differ from Preferred Provider benefits and are based on your selections below when applying for a Preferred Provider plan. See the product brochure for details and refer to the Policy Schedule of Benefits when the coverage is issued.

<input type="checkbox"/> Deluxe Plan <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"/> 60% <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"/> Advantage Plan <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"/> Value Plan <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"/> High Deductible Health Plan <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"/> No HSA	<input type="checkbox"/> Copay Plan <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"/> Premier Plan <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 <i>(Discount Drugs Only is not an insurance benefit)</i>	<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
24-hour Occupational Coverage	Sole proprietors, partners (ownership over 10%), or business owners not covered by Workers' Compensation are eligible. Do you qualify for this benefit? (Verification may be necessary.) Applicant: <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No
Health Empowerment Package	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(This is not a health insurance benefit)</i>
Mental Disorders Coverage	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

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

Spouse's Name Last _____ First _____ Initial _____				Social Security Number		
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 1st of the month following approval.
- I request an effective date of _____ (must be the 1st or 15th 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.

24-hour Occupational Coverage (complete only if applying for optional 24-hour Occupational Coverage):

1. Is any person to be insured currently covered under Workers' Compensation? Applicant: Yes No Spouse: Yes No
2. Are you eligible to opt out of Workers' Compensation and are you a Sole proprietor, Partner, or Owner?
 Applicant: Yes No Spouse: Yes No

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 No
 Is 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, ridered, 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, ridered, 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 within the last 10 years 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, 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 7 years, has any person to be insured had any 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.

INSTRUCTIONS: 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?	<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 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
Was there a break in health insurance coverage in excess of 90 days during the past 12 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
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.

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.

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

Fraud Statement: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or for the purpose of misleading, conceals information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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 _____ on the _____ day of _____, 20____.
City State Month 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

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK
485 Madison Avenue, New York, NY 10022

PPO HEALTH INSURANCE COVERAGE – SSL IP GA 607
OUTLINE OF COVERAGE

READ YOUR POLICY CAREFULLY! This Outline of Coverage provides a brief description of the important features of your policy. This is not the insurance contract and only the actual policy will control. The policy itself fully sets forth the rights and obligations of both you and your insurance company. It is therefore, important that you **READ YOUR POLICY CAREFULLY!**

MAJOR MEDICAL EXPENSE COVERAGE. The policy is designed to provide, to the persons insured, coverage of major hospital, medical, and surgical expenses incurred as a result of a covered injury or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, out-of-hospital care, subject to any calendar year deductibles or daily deductibles, copays and/or coinsurance provisions, or other limitations which may be set forth in the policy. The policy contains participating provider benefits.

The policy covers the following covered charges for a covered person in connection with the treatment of a injury or sickness if the charges are: (a) medically necessary; (b) usual and reasonable; (c) authorized by a physician; (d) incurred while the policy is in force, and (e) not excluded or limited by exclusions and limitations from coverage. Covered charges are subject to the calendar year deductible(s) or daily deductibles; copays, coinsurance percentage(s), and the limitations and maximums specified on the schedule of benefits of the policy.

If a covered person incurs covered medical expenses, we will pay the negotiated fee or the usual and reasonable charge for the area where the service is rendered. All covered charges will first be applied to the calendar year deductible or daily deductible unless otherwise specified in the policy. Benefits are payable after the calendar year deductible or daily deductible and any applicable co-payments as set forth in the policy have been satisfied and will be subject to the coinsurance amount, out-of-pocket maximum and policy maximums. The calendar year deductible or daily deductible, coinsurance and co-payments will vary depending upon the plan you selected. The family calendar year deductible and family calendar year out-of-pocket maximum can be met by one covered person or any combination of covered persons. Procedures and services subject to a separate co-payment are shown on the policy's schedule of benefits. The covered person has the freedom to use any provider. **If you are covered under a PPO Plan, it contains different levels of benefits providers. The amounts you pay may be higher when nonpreferred providers are used. Under the PPO Plans, all medical benefits for emergency services will be considered for payment at the preferred provider benefit level, limited to the usual and reasonable charge.** Payment of benefits will be subject to the lifetime maximum benefit for all benefits, as shown on on the policy's Schedule of Benefits, while covered under the policy per covered person

This is a Preferred Provider Organization coverage. There may be differences in benefits provided under this Policy when a Covered Person receives Covered Charges from either a Preferred Provider or Non-Preferred Provider as benefits are payable on a Preferred Provider Organization basis. We pay Covered Charges at the Preferred Provider rate or Non-Preferred Provider rate shown in the Schedule of Benefits. A Covered Person must normally receive Covered Charges within the Preferred Provider service area to assure that they will be reimbursed at the Preferred Provider rate. If a Covered Person uses a Non-Preferred Provider solely because he or she receives Emergency Care, then the benefits will be paid on the same basis as if the Covered Person had used the services of a Preferred Provider.

BENEFITS: The following is a brief listing of the covered charges under the policy; refer to the policy for a complete listing of covered charges.

Hospital room and board at the most common daily rate. • Skilled nursing facility room and board • Ambulatory surgical center services • Urgent care facility service and professional fees • physician services, including home, office and hospital visits, surgery, and other medical care and treatment • Outpatient services by a registered nurse • Professional licensed ambulance services as shown on the policy's Schedule of Benefits• Medical services and supplies • Anesthetics, oxygen and their administration • Mastectomy as a result of a diagnosis of breast cancer • Child wellness services from birth through the age of 5 years which are rendered during a periodic review and during the course of one visit. No Calendar Year Deductible Daily Deductible or Copay applies to this Benefit. Preventive care services for covered dependent children from birth until 18 years of age as follows: (i) Unlimited preventive screening visits for children up to the age of 12 years; and (ii) 3 preventive screening visits per calendar year for minor children ages 12 years up to 18

years of age; • Low-dose screening mammography as follows: (i) Age 35 – 39 – a single baseline mammography; (ii) Age 40 and older – yearly; and (iii) A mammogram at the age and intervals considered medically necessary, as recommended by a physician, for any woman who is at risk for breast cancer. • One cervical smear or pap smear for the early detection of cervical cancer and endometrial cancer per calendar year, and as needed upon certification by an attending physician that the test is medically necessary and the physician's office visit in connection with the cervical or pap smear • One digital rectal examination and a prostate cancer screening known as prostate specific antigen (PSA) test and the physician's office visit in connection with the examination per calendar year for male insureds age 50 and over; and for male insureds age 40 and over who are in high-risk categories according to the most current American Cancer Society prostate cancer screening guidelines.

• Colorectal cancer examinations and laboratory tests for colorectal cancer and the physician's office visit in connection with this cancer screening for covered persons who are 50 years of age or older, or less than fifty (50) years of age and at high risk for colorectal cancer according to the most current American Cancer Society colorectal cancer screening guidelines • Chlamydia screening test for female Covered Insureds 29 years of age and younger. • Surveillance tests for women age 35 and over who are at risk for ovarian cancer. • Routine physical examinations, covered only if the optional Preventive Care Benefit Rider is specified as applicable on the Schedule of Benefits, as follows: (i) one routine physical examination of the heart, lungs and abdomen by a physician per calendar year; (ii) such diagnostic tests as may be required, and that are performed during the routine physical examination or in conjunction with the exam; (iii) an evaluation of the covered person's general health status by his or her primary physician; (iv) an annual flu shot; and (v) Human Papillomavirus Vaccines, approved by the U.S. Food and Drug Administration and administered in accordance with the recommendations by the Advisory Committee on Immunizations Practices • Outpatient diabetes self-management training and education, pharmacologic agents, equipment and supplies for the treatment of type 1 diabetes, type 2 diabetes, and gestational diabetes mellitus. • Oral surgery including cutting procedures for the treatment of tumors, abscesses or cysts or injuries to the jaw. • Physical, speech or occupational therapy as shown on the policy's Schedule of Benefits • Human organ and tissue transplant services • Outpatient treatment of chemical dependency disorders up to the lifetime maximum; and dollar amount per visit; and visit maximums per covered person per calendar year as shown on the policy's Schedule of Benefits. • Inpatient and outpatient treatment of mental or nervous disorders by a physician, psychologist, or a mental health professional up to the lifetime maximum; and dollar amount per visit; and visit maximums per covered person per calendar year. Mental or Nervous Disorders includes Autism. • Hospice care services provided under active management through a hospice. 6 months of covered charges: • Home health care services when provided in the covered person's home by a home health care agency up to the maximum amount of visits as specified on the Schedule of benefits per each calendar year per covered person • Non-Surgical back treatment up to a maximum of per covered person per calendar year as shown on the Schedule of Benefits. • Covered Charges for routine patient care cost for Dependent children enrolled in approved clinical trial programs for the treatment of children's cancer who: (a) are covered Insured's under the Policy; (b) have been diagnosed with cancer prior to their 19th birthday; (c) enrolled in an approved clinical trial program for treatment of children's cancer; and (d) are not otherwise eligible for benefits, payments, or reimbursement from any other third party payor or other similar sources. • Diagnostic and surgical treatment of Temporomandibular joint (TMJ) Disorder subject to the following conditions: (a) coverage provided shall be the same as that for treatment of any joint in the body; and (b) treatment shall be considered a Covered Charge if services are provided by a licensed Physician or dentist. • General anesthesia and associated Hospital or Ambulatory Surgical Center charges for dental care for a Covered Person if the Covered Person is: (a) seven (7) years of age or younger or is developmentally disabled; (b) an individual for which a successful result cannot be expected from dental care provided under local anesthesia because of a neurological or other medically compromising condition of the Covered Person; or (c) an individual who has sustained extensive facial or dental trauma, unless otherwise covered b Workers' Compensation Insurance. • Covered Charges for telemedicine services that are appropriately provided through telemedicine and generally accepted health care practices and standard prevailing in the applicable professional community at the time the services were provided. • Benefits are provided for qualified individuals for reimbursement for scientifically proven bone mass measurement (bone density testing) for the prevention, diagnosis, and treatment of osteoporosis. • Reconstructive procedures, or complications of such procedures. • Medical treatment, services and supplies received in a retail health clinic for the treatment of a covered sickness or injury.

EXCLUSIONS AND LIMITATIONS FROM COVERAGE: Except as specifically provided for in the policy, the policy does not cover any of the following charges, treatment, services or supplies for or related to: This limitation shall not apply to charges incurred for a pre-existing condition, unless the condition is specifically excluded under the policy, or excluded by endorsement or rider attached to the policy, if at the end of a continuous 12-month period commencing on or after the effective date of the covered person's coverage, the person has not received medical advice, diagnosis, care, or treatment in connection with such injury or sickness or, at the end of the two (2) year period during which the person has been continuously covered under this Policy. A pre-existing condition will be considered a covered charge if it is duly disclosed in the application for coverage of the covered person and otherwise covered by the policy, unless the condition is specifically excluded by endorsement or rider attached to the policy. • Equipment including, but not limited to, modifications to motor

vehicles or motor homes such, as wheelchair lifts or ramps; water therapy devices, such as Jacuzzi's or hot tubs; and exercise equipment. • Physical examinations, immunizations and check-ups which are not medically necessary for the treatment of injury or sickness, unless the Preventive Care Benefit Rider is specified as applicable on the schedule of benefits. • Prophylactic treatment, surgery or diagnostic testing. • Outpatient prescription medications, including, but not limited to, specialty medications unless the Optional Prescription Medication Benefit Rider is specified as applicable on the schedule of benefits. • Any service or supply in connection with the implant of an artificial organ. • Any treatment, service, supply, or prescription medication which: (a) is not due to a sickness or injury; (b) is not recommended by a physician; or (c) is not medically necessary. • Treatment, services or supplies for which no charge is made or for which the covered person is not required to pay. • Any treatment, service or supply provided by a government owned or operated facility or by government employed health care providers, unless the insured person is legally required to pay the charges incurred or we are required to provide reimbursement by local, state or federal law. • Hospital and physician charges for weekend hospital admissions occurring between noon on any Friday and noon the following Sunday for non-emergency procedures, unless medically necessary or unless surgery is scheduled for the next day. • An Injury or Sickness which arises out of or in the course of any employment for wage or profit • Physical or psychological examinations required by any third party, such as by a court or for employment, licensing, insurance, school, sports or recreational purposes, and the completion of any forms for such examinations. • An injury or sickness incurred while on active duty with the military of any country or international organization. • An injury or sickness resulting from war or any act of war (declared or undeclared) or the participation in a riot or insurrection. • An injury or sickness incurred: (a) during the commission or attempted commission of a felony or to which a contributing cause was the Covered Persons being engaged in an illegal occupation; • Treatment, services or supplies for any loss sustained, incurred due to, or contracted as a consequence of a covered person: (a) being intoxicated; or (b) being under the influence of any narcotic, barbiturate, hallucinatory or other drug, unless administered by a physician and taken in accordance with the prescribed dosage; or (c) being under the influence of any illegal drug as defined by state or Federal law. A covered person is conclusively determined to be intoxicated by drug or alcohol if a test, including but not limited to a chemical or breath test, administered in the jurisdiction where the loss or cause of loss occurred is at or above the legal limit set by that jurisdiction. • Treatment, services or supplies related to: (a) the teeth; gums and any other associated structures except for tumors, cuts, and injuries; (b) the prevention or correction of teeth irregularities and malocclusion of jaws by wire appliances, braces or other mechanical aids; (c) dental implants, regardless of the cause; and (d) extraction of impacted, unerupted teeth. • Treatment, services or supplies as the result of prognathism, retrognathism, micrognathism, or any treatment, services or supplies to reposition the maxilla (upper jaw), mandible (lower jaw), or both maxilla and mandible, unless due to an injury, which occurs while covered under the policy, to sound natural teeth, provided that such treatment is received within 90 days following the date of Injury. • Treatment, services or supplies provided for temporomandibular joint (TMJ) dysfunction except as provided in Section 3- Benefits; • Treatment, services or supplies to improve the appearance or self-perception of a covered person, which does not restore a bodily function including, but not limited to, cosmetic or plastic surgery, hair loss or skin wrinkling, or the complications of any such treatment. • Treatment, services or supplies for: (a) breast augmentation; (b) the removal of breast implants unless medically necessary and related to surgery performed as reconstructive surgery due to a sickness; and (c) breast reduction surgery unless medically necessary due to a sickness. • Surgery to correct refractive errors, such as radial keratotomy or radial keratectomy. • Routine eye exams, glasses, visual therapy, or contact lenses, except for the first pair of glasses or lenses for use after cataract surgery. • Routine hearing exams to assess the need for, or change to, hearing aids; and the purchase, fittings or adjustments of hearing aids; and the surgical or non-surgical treatment for the improvement of hearing including, but not limited to, the insertion of hearing aids or implants, except if such treatment was incidental to or follows a covered injury or sickness occurring while coverage under the policy is in force. • Contraceptive drugs and, devices, including, but not limited to, injectible, implantable or intradermal patch contraceptives, and any professional service fees related to the insertion or removal of such contraceptives,. • Pregnancy and related services of a covered person,

• A newborn's well baby charges including, but not limited to, hospital expenses, nursery charges and charges incurred for circumcision. • Penile implants, treatment of fertility, except for the initial diagnosis of infertility, and sterility studies; • Treatment, services or supplies: (a) to restore or enhance fertility; or (b) to reverse sterilization. • Vasectomy or tubal ligation for the purpose of voluntary sterilization. • Impregnation techniques such as: (a) artificial insemination; or (b) in vitro fertilization; including but not limited to: artificial insemination, in vitro zygote and intra-fallopian transfers, gamete intra-fallopian transfer, genetic counseling, and all charges related to such in vitro fertilization. • Voluntary abortion; except if the life of the mother would be in danger if the fetus were carried to term, or except for complications of a voluntary abortion. • The non-therapeutic release of nuclear energy. • Hypnosis. • Attempted suicide or intentionally self-inflicted injury or sickness, while sane or insane; • Treatment, services or supplies for inpatient chemical dependency disorders. • The voluntary taking of poison. • The voluntary inhaling of gas. • Treatment, services or supplies to eliminate or reduce a dependency on or an addiction to tobacco, including but not limited to: nicotine withdrawal programs; nicotine products, such as transdermal patches and gums; hypnotism; and goal oriented behavioral modification. • Marriage or family counseling. • Any therapy not listed as a covered charge including, but not limited to massage therapy, recreational therapy, equine therapy, hippotherapy, educational therapy, social therapy, art therapy, music therapy, sex therapy; or

any speech or occupational therapy if the therapy is in connection with or related in any way to the treatment of a learning disability, speech impediment, or developmental delay even if therapy is recommended due to organic dysfunction, including, but not limited to, congenital deformity or birth trauma. • Sexual reassignments or sexual dysfunctions or inadequacies. • Meridian therapy (acupuncture), except when used in lieu of an anesthetic. • Treatment, services or supplies related to paring or removal of corns, calluses, bunions or toenails (other than partial or complete removal of nail roots), except when prescribed by an attending physician who is treating the covered person for a metabolic disease, such as diabetes mellitus or a peripheral-vascular disease such as arteriosclerosis. • Treatment, services or supplies related to the feet by means of posting or strapping, or range of motion studies. • Orthotics. • Treatment, services, supplies for obesity, extreme obesity, morbid obesity or weight reduction, including, but not limited to, wiring of the teeth and all forms of surgery including, but not limited to, bariatric surgery, intestinal bypass surgery and complications resulting from any such surgery. • Treatment, services or supplies received from a physician, nurse or other provider if such provider: (a) is a close relative of the insured person; or (b) lives in the same household as the covered person, except for charges rendered while a hospital inpatient.

• Treatment, services or supplies received from a physician, nurse or other provider if such provider is an owner, partner, officer, director or employee of the same employer as the covered person; except for charges rendered while a hospital inpatient. • Treatment, services or supplies that are experimental medical treatment, procedure or medication. • Any surgical removal of an organ or tissue unless medically necessary. • Private duty nursing. • Any over-the-counter medication or medication that may be obtained without a prescription. • Custodial care, regardless of who prescribes or renders such care. • Treatment, services or supplies received or purchased outside the United States unless the charges are incurred while traveling on business or for pleasure, for a period not to exceed 90 days, and the charges are incurred for urgent care, provided the treatment, services or supplies used in connection with the urgent care are approved for use in the United States. • Any education or training materials including, other than those used for diabetes self-management training and education, but not limited to, programs or materials for pre-natal education and management of pain, asthma and heart disorders. • Inpatient personal convenience items including, but not limited to, beauty or barber services, radio and television, massages, telephone charges, take home supplies, guest meals, and motel accommodations. • Email consultations, missed appointment fees, fees for completing claim forms, and fees related to the provision of medical records. • Treatment, services or supplies for complications of conditions that are not covered under the policy except for complications of a voluntary abortion. • Any conditions specifically excluded by riders, endorsements, or exclusions attached to the policy. • Charges incurred after coverage under the policy terminates, regardless of when the condition originated. • Charges in excess of the usual and reasonable charges. • Charges incurred to treat complications resulting from treatment, drugs, supplies, devices, procedures or conditions which are not covered under the policy. • Charges determined by us to be unbundled charges.

PROVIDER NETWORKS: Reimbursement for covered charges varies depending on the provider that the covered person selects to provide treatment, services or supplies. If treatment, services or supplies are obtained or received from a Non-Preferred provider, unless otherwise stated herein, the following applies: (i) Covered charges will be reimbursed at the Non-Preferred benefit level; (ii) Charges will be reduced to the usual and reasonable charge, as determined by us, for such treatment, service or supply before being considered a covered charge; and (iii) the covered person will be responsible for any portion of the charges that exceed the usual and reasonable charge for such treatment, service or supply. When a covered person receives treatment, services or supplies at a Preferred facility from a Non-Preferred anesthesiologist, assistant surgeon, pathologist or radiologist, covered charges will be paid at the Preferred Provider benefit level subject to the usual and reasonable charge.

If a covered person is taken to a Non-Preferred physician or facility for emergency care, benefits will be paid by us at the Preferred level of benefit as specified in the schedule of benefits subject to the usual and reasonable charge. However, the insured person must arrange transfer to a Preferred hospital within 48 hours, or as soon as the transfer may take place without detriment to the covered person's health. Otherwise, benefits will be reduced to the Non-Preferred provider benefit level subject to the usual and reasonable charge.

TERMINATION OF INSURANCE: Insurance shall terminate on the earliest of the following dates:

1. The next premium due date after we receive your written request to terminate coverage under the policy;
2. The premium due date, if the premium then due is not paid by the end of the grace period;
3. The date the insured person or dependent has been determined by us to have committed an act of fraud or made an intentional misrepresentation of material fact when applying for coverage under the terms of the policy;
4. The date the insured person or dependent reaches the Maximum benefit while covered under the policy as specified in the schedule of benefits;
5. The first date following 90 days advance written notice by us to the insured person and the Commissioner when we may lawfully discontinue offering coverage under the policy in the state where the policy was issued;

6. The first date following 180 days advance written notice by us to the insured person and the Commissioner when we may lawfully discontinue offering all health insurance coverage in the individual market in the state where the policy was issued;
7. The date of death of the insured person or dependent; or
8. The premium due date coinciding with or following the date of the termination of the policy.

PREMIUMS: We reserve the right to change premiums under the policy on any premium due date by giving the insured person at least 60 days prior written notice.

If the insured person has selected an initial rate guarantee period when applying for the policy, the premium will not change during the initial rate guarantee period except for the following reasons: (1) The addition or deletion of dependents to or from the policy; (2) A covered person enters into a new age rate-band; (3) The insured person changes the network provider organization to a network provider organization that is different than the network provider organization he or she selected when applying for coverage; (4) The insured person moves to a different location from where the insured person was located at the time they applied for coverage; (5) The insured person requests that the policy be modified to increase or decrease benefits from those selected when applying for coverage; or (6) Change in benefits as mandated by new state or federal statutes, rules or regulations which become effective after the effective date of coverage and affect our liability under the policy.

BENEFIT RIDERS

Optional Supplemental Accident Benefit Rider – SSL ISABR 607

Optional Preventive Care Benefit Rider – SSL PCBR GA 607

Optional Prescription Medication Benefit Rider – SSL IPMBR GA 607

Optional 24-Hour Occupational Coverage Benefit Rider – SSL IOCR GA 607

Optional Mental Disorders Benefit Rider – SSL AEMDBGA 607

Online Fulfillment Supplemental Form

To Proposed Insured:

If insurance coverage is approved for me and/or my dependents:

_____ I agree to obtain my insurance policy and related documents by downloading them from the Web site.

_____ I don't agree to obtain my insurance policy and related documents by downloading them from the Web site, and want to receive them by U.S. Mail.

Name of Applicant or parent, if Applicant is under age 18

Date

Signature of Applicant or parent, if Applicant is under age 18