

**HCC Life Short Term Medical Plan
Enrollment Form
For use in CT**



(Herein referred to as HCC Life)

Please submit completed applications with payment to:

HCC Life Insurance Company
P.O. Box 863
Indianapolis, IN 46206

- Please complete this application entirely. Failure to provide complete information may delay processing.
- You may elect the Single Payment option for 6 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	

* With respect to a civil union established in the State of CT, the term "Spouse" includes a partner in such civil union with the "Primary" enrollee

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
Coinsurance	<input type="checkbox"/> 80% of \$5,000 <input type="checkbox"/> 50% of \$5,000	<input type="checkbox"/> Single Up Front (please specify termination) Specify Term Date _____
Requested Effective Date		Number of days (max 180) _____

Medical Questions	Please answer the questions below (to the best of your knowledge and belief) 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: 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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/bulge, rheumatoid arthritis, kidney disorder, diabetes, degenerative joint disease of the knee, alcohol abuse or chemical dependency, mental/nervous disorders or any neurological disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Within the last 5 years has any applicant ever had, been told they had or has any applicant ever been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or AIDS related conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Are you a sole proprietor or a self-employed individual that: (1) is actively at work for a minimum of (30) thirty hours per week; and (2) has been in business for (3) three consecutive months? By checking "No" you certify to HCC Life that you are not a sole proprietor or self-employed as stated.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. 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 5 or "No" to question 6 above, coverage cannot be issued. Thank you for your interest.	

For product information or assistance with this application, please contact:

Alan D. Sheketoff
585 Villa Av.
Fairfield, CT 06825
Phone: 203-384-9000 Fax: 203-366-6596
macmaninsurance@aol.com

Rate Calculation		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	Total Due Monthly: H + K = Daily: J + K =	L	L

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 the insurance issued to 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 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.			
Applicant Signature	Date	Spouse Signature	Date
Signed by HCC Life Appointed Agent:		Plan Administrator Use Only:	
		PBC 6CT.110.05.10	Code: 235980003A

THIS PLAN EXCLUDES COVERAGE FOR CONDITIONS FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT WAS RECOMMENDED OR RECEIVED DURING THE TWENTY-FOUR MONTHS IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF COVERAGE.