Short Term Medical Insurance Application

462 Midland Rd
Janesville, WI 53546

Fairmont Specialty
a division of Crum & Forster

Step 1: Applicant Information

Name | Date of Birth | Age | Sex | Social Security Number | Occupation | Telephone

Street Address | City | State | Zip

Billing Address (if different) | City | State | Zip | E-mail Address

Complete the following to insure your spouse and/or children:

Spouse Name | Date of Birth | Age | Sex | Ht. | Wt. | Social Security Number | Occupation

Child's Name | Date of Birth | Age | Social Security Number | Child's Name | Date of Birth | Age | Social Security Number

Child's Name | Date of Birth | Age | Social Security Number | Child's Name | Date of Birth | Age | Social Security Number

Child's Name | Date of Birth | Age | Social Security Number | Child's Name | Date of Birth | Age | Social Security Number

Step 2: Complete the Following Choices

Coverage Effective Date:
- ☐ Day after US Post Date Stamp
- ☐ Later Effective Date:____________

Deductible:
- ☐ $250 ☐ $1000
- ☐ $500 ☐ $2500

Payment Method:
- ☐ Check or Money Order
- ☐ Credit Card
- ☐ Monthly Automatic Bank Withdrawal

Coinsurance Choice:
- ☐ 80/20 of $5000
- ☐ 50/50 of $5000

1-6 Months Coverage:
☐ Monthly Payments

1-12 Months Coverage:
☐ Monthly Payments

Single Payment:
________ days (maximum 185 days)

Step 3: Answer the Following Medical History Questions

Any material misstatement or omission of information made on this form will be considered a misrepresentation and may be the basis for later rescission of my coverage and that of my dependants. In the event of rescission or termination for any reason, the Insurer shall have the right to deduct any premium due and unpaid from any claims payable to me or my dependents.

1. Will there be any other health insurance in force on the policy date? ☐ yes ☐ no
2. Is the proposed insured, spouse, or any dependent child now pregnant? ☐ yes ☐ no
3. Is any proposed insured currently eligible for Medicaid? ☐ yes ☐ no
4. Has any person proposed for coverage been declined for health insurance in the past 12 months? ☐ yes ☐ no
5. Within the past 5 years have you been aware of, diagnosed, treated by a member of the medical profession, or taken medication for cancer or tumor, stroke, heart disease including heart attack, chest pain or had heart surgery, COPD (chronic obstructive pulmonary disease) or emphysema, liver disorder, degenerative disc disease or herniation/bulge, rheumatoid arthritis, degenerative joint disease of the knee, insulin-dependant diabetes, alcohol abuse or chemical dependency? ☐ yes ☐ no
6. Have you been diagnosed or treated for AIDS, AIDS-related complex, or any other immune system disorder? ☐ yes ☐ no
7. Has any person proposed for coverage not been a legal resident of the United States for the last 12 consecutive months? ☐ yes ☐ no

NOTE: If "Yes" is answered on any question 1 through 7, coverage cannot be issued.

1. I agree that coverage will not become effective for any person whose medical history changes prior to coverage approval, such that the person's answer would be "yes" to any of the Medical History questions in this application. If such person is the Applicant, coverage is automatically declined for all persons included in this application.
2. I hereby request coverage under the policy issued to the group policyholder by the insurer and understand that if the coverage applied for becomes effective, I agree to all terms of the group policy. I understand that health insurance benefits are excluded for pre-existing conditions.
3. I hereby authorize any hospital, clinic, physician, surgeon, practitioner or insurance company to furnish the Insurer or its representative with any and all information concerning any sickness or injury I or my dependents may have suffered, including copies of all hospital or medical records. A copy of this authorization shall be considered as valid as the original and remains in effect for 2 years from the date of my signature.
4. I understand that the broker who solicited this application was acting as an independent contrator and not as an agent of United States Fire Insurance Company. I further acknowledge that the person who solicited this application and upon whose explanation of benefits, limitation or exclusions we relied, was retained by me as my agent, and that such person has no right to bind or approve coverage or alter any of th terms of conditions of the policy.
5. I have read this application and have verified that all of the information provided in it is complete, true and correct, and is all within my personal knowledge. I agree to immediately notify the insurer of any changes in any of the information contained in this form which may occur prior to the approval of coverage.

Fraud Warning: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.

I understand that this coverage will not pay benefits for a disease or physical condition that I now have or have had in the past.

Signature of Applicant:________________________ Date:__________ Signature of Spouse:________________________ Date:__________

AHU27286 Rev. 01-01-2007 Underwritten by United States Fire Insurance Company

Step 4: Provide Payment Information

Credit Card Payment Request:

I authorize SASID, INC to charge my credit card premium and fees once for Single Pay Option; or the 1st month and each month thereafter for the Monthly Pay Option.

- ☐ **Visa**
- ☐ **Master Card**
- ☐ **Discover Card**

Account Number | Exp. Date | Sec. Code

Print Account Holders Name (As it appears on the card)

Signature of Cardholder | Date

Automatic Check Withdrawl Request:
By selecting automatic check withdrawl, your SASID, INC monthly premium and fees will automatically be withdrawn from your checking account until the term of insurance expires. **Complete the form below. Attach a voided check and a check for the first month premium and fees.**

Print Name of Bank or Institution

Address of Bank or Institution

Signature of Premium Payer | Date

I authorize SASID, INC to charge my account for the Short Term Medical policy listed above, until the end of the policy or until I request cancellation in writing. I understand I can request the charge be stopped if I notify SASID, INC five days in advance of the charge occurring.