

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: <input type="checkbox"/> Day after US Post Date Stamp <input type="checkbox"/> Later Effective Date: _____	Deductible: <input type="checkbox"/> \$250 <input type="checkbox"/> \$1000 <input type="checkbox"/> \$500 <input type="checkbox"/> \$2500
Payment Method: <input type="checkbox"/> Check or Money Order <input type="checkbox"/> Credit Card <input type="checkbox"/> Monthly Automatic Bank Withdrawal	Coinsurance Choice: <input type="checkbox"/> 80/20 of \$5000 <input type="checkbox"/> 50/50 of \$5000
1-6 Months Coverage: <input type="checkbox"/> Monthly Payments	1-12 Months Coverage: <input type="checkbox"/> 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 dependants.

- Will there be any other health insurance in force on the policy date? yes no
- Is the proposed insured, spouse, or any dependent child now pregnant? yes no
- Is any proposed insured currently eligible for Medicaid? yes no
- Has any person proposed for coverage been declined for health insurance in the past 12 months? (Missouri residents do not have to answer) yes no
- 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 (not applicable to DC residents), alcohol abuse or chemical dependency? yes no
- Have you been diagnosed or treated for AIDS, AIDS-related complex, or any other immune system disorder? yes no
- 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.

- 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.
- 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.
- 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.
- I understand that the broker who solicited this application was acting as an independent contractor 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, limitations 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 the terms or conditions of the policy.
- 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.

For all residents except Virginia residents: 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.

Notice: Genetic information, receipt of genetic services or refusal to submit to a genetic test may not be used to terminate, cancel, limit, non-renew or deny coverage or establish differentials in premiums.

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: _____

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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
 MasterCard
 Discover Card

Account Number _____ Exp. Date _____
 Print Account Holders Name (As it appears on the card) _____
 Signature of Cardholder _____ Date _____

Automatic Check Withdrawal Request:

By selecting automatic check withdrawal, 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.