Short Term Medical Enrollment Form — Texas

REQUESTED PLAN DATE		
MONTH	DAY	YEAR

Coverage begins day after approved plan date.

Note: Effective date is assigned by Fortis Insurance Company.
The effective date cannot be earlier than:
1. The day after: a) this form is signed; b) the date this form is postmarked for mailing to us; or c) the date we receive your enrollment request by electronic transmission, OR 2. If dates cannot be determined, the day we receive this form by mail. **The agent cannot assign an effective date different than this.**

FORTIS
Solid partners, flexible solutions™

CERTIFICATE/POLICY NUMBER

APPLICANT'S NAME (Print Last, First, Middle)	SEX	BIRTHDATE	SOCIAL SECURITY NUMBER
		/ / /	— —
STREET ADDRESS	CITY, STATE, ZIP CODE		
SPOUSE'S NAME (If to be insured)	SEX	BIRTHDATE	SOCIAL SECURITY NUMBER
		/ / /	— —

CHILDREN (Name) (if to be insured)	BIRTH DATE	NAME	BIRTH DATE	NAME	BIRTH DATE
1.		3.		5.	

NOTE: The plan cannot be issued if YES is answered to any questions. Under no circumstances can coverage become effective prior to the date this application is signed.

Answer the following questions completely and accurately — Yes / No

1. Will you or any person to be insured have any hospital, Major Medical or group health insurance in force on the effective date of this plan? ☐ Yes ☐ No
2. Have/Are you, your spouse, or any person to be insured: ☐ Yes ☐ No
   - been denied insurance due to health reasons?
   - now pregnant, an expectant parent or in the process of adopting a child?
   - over 300 pounds if male, or over 250 pounds if female?
3. For any of the following conditions, within the last 5 years, have you or any person to be insured received any abnormal test results or medical or surgical treatment, or consulted a health care professional, or taken medication for: ☐ Yes ☐ No
   - heart disorder including but not limited to heart attack or chest pain?
   - chronic respiratory conditions including but not limited to emphysema
   - stomach or ulcer symptoms; colitis or Crohn's disease; or hepatitis?
   - immune system disorder or tested positive for HIV?
   - uncorrected gall bladder disease or gallstones?
   - stroke or circulatory system disorders?
   - kidney disease?
   - diabetes?
   - cancer, tumor or internal cyst?
   - alcoholism or alcohol abuse?
   - chemical dependency or drug abuse?

Note: The plan cannot take effect prior to the termination date of existing coverage, or cannot be issued if YES is answered on any questions, 2-3. Under no circumstances can coverage become effective prior to the date this application is signed.

Length of Coverage	Deductible Amount		Lifetime Maximum	Payment Option	Rate of Payment	TOTAL
☐ Up to 6 months	☐ $250	☐ $1,000	☐ $2 Million	☐ Single payment:	☐ 100%*	
	☐ $500	☐ $2,500	☐ $5 Million	____________ Days	☐ 80%	
	** not available with 100% Rate of Payment*				☐ 50%	
☐ Up to 12 months	☐ $500	☐ $2,500	☐ $1 Million	☐ Monthly payment:	* not available on policies longer than 6 months	
	☐ $1,00	☐ $5,000	☐ $2 Million			

Optional Riders Available ☐ Rehabilitation Therapies Benefit

The undersigned attests that the information above is true to the best of his/her knowledge. The undersigned realizes that any false, or intentional misrepresentation of a material fact in the enrollment form may result in claim denial or contract rescission. Any person who injures, defrauds, or deceives any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information may be guilty of a felony of the third degree. The undersigned understands that the plan applied for will not pay benefits for any expenses incurred on account of any condition which manifested itself before the effective date.

Insured acknowledges receipt of an Outline of Coverage with this application.

PRIMARY PHYSICIAN'S NAME (IF ANY) ____________ PRIMARY PHYSICIAN'S TELEPHONE NUMBER (OPTIONAL) ____________

APPLICANT'S SIGNATURE ____________ TODAY'S DATE ____________

EMAIL ADDRESS ____________ DAY TELEPHONE NUMBER ____________ EVENING TELEPHONE NUMBER ____________

Form 28243-TX

Please indicate your method of payment for the policy:

☐ Check or Discover ☐ VISA / MasterCard Card # ____________ Exp. date ________ Authorized Amount $ ________

☐ Automatic charge to checking account (Attach a voided check)

☐ **When selecting a single payment or Discover Card:** I authorize Fortis Insurance Company to charge my account for the Short Term Medical policy listed above. I understand there will be no refund of premium after the 10-day free look period in the contract. The $20 application fee is non-refundable.

☐ **When selecting monthly payment with VISA / MasterCard / Automatic Charge to a checking account:** I authorize Fortis Insurance Company to charge my credit card each month, for the Short Term Medical policy listed above, until the end of the policy or I request cancellation. I understand I can request the charge be stopped if I notify Fortis Insurance Company 7 days in advance of the charge occurring. I also understand there will be no refund of premium after the 10-day free look period
in the contract.
The $20 application fee is non-refundable.
When selecting a single payment or Discover Card: I authorize Fortis Insurance Company to charge my credit card for the Short Term Medical policy listed above. I understand there will be no refund of premium after the 10-day free look period in the contract. The $20 application fee is non-refundable.

Signature of Account Holder: ______________________________ Date: ______________

Agent Name: ______________________ Agent ID Number: ______________ App Source: ____________

Mail completed application to agent listed

Stockstill & Associates
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