UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: 5 Christopher Way • Eatontown, NJ 07724
(a stock company, here referred to as the Company)

FIXED INDEMNITY INSURANCE APPLICATION

This policy provides fixed indemnity insurance coverage. It is designed to provide fixed amounts for certain medical services for a covered injury or sickness. Benefit amounts are based on a schedule of benefits. Benefits are not based on the actual cost of health care services. As a fixed indemnity product, this policy is not subject to the ACA requirements for comprehensive health insurance coverage. This policy DOES NOT provide "minimum essential coverage" or "essential health benefits."

Please call our Member Care team at the toll-free number 1-877-653-6440 with any questions about this application.

NAME ______________________ ______________________
First Last

SEX ________ ________
Male Female

DATE OF BIRTH ________ ________ ________
Month Day Year

EMAIL ______________________

ADDRESS ______________________ ____________ AL ________
Street City State Zip

PHONE NUMBER ______________

SOCIAL SECURITY NUMBER ______________

Please fill out a separate application for each family member.

MEDICAL QUESTIONNAIRE

Have you in the past 5 years been diagnosed with, or treated for, any of the following?

Condition	Yes	No
AIDS/HIV	Yes ________	No ________
Diabetes	Yes ________	No ________
Heart Disease	Yes ________	No ________
Mental Health Disorder	Yes ________	No ________
Kidney/Renal Failure	Yes ________	No ________
Blood Disorders	Yes ________	No ________
Liver Disease	Yes ________	No ________
Lung Disease	Yes ________	No ________
Muscular Dystrophy	Yes ________	No ________
Systemic Lupus	Yes ________	No ________

Transplant Yes ______ No ______

Rheumatoid Arthritis Yes ______ No ______

Cancer Yes ______ No ______

Have you had any of the following in the last five years?

Back Surgery Yes ______ No ______

Hepatitis C Yes ______ No ______

Weighed over 300 lbs. as a male or 260 lbs. as a female Yes ______ No ______

In the past 12 months, have you?

Visited a chiropractor five or more times Yes ______ No ______

Visited a licensed mental health professional five or more times Yes ______ No ______

Used tobacco products in any from Yes ______ No ______

Are you currently?

Dependent on a device that helps with walking, breathing, dialysis, etc. Yes ______ No ______

Pregnant Yes ______ No ______

What prescribed medical treatments (procedures, services, devices, or medication) do you expect to receive in the next 12 months?

____

What prescriptions do you take regularly?

____

Would you like to provide any additional clarifying information about your answers above?

____

Deductible: ______________________________

Total Policy Year Maximum: ______________________________

Outpatient Prescription Drug: **Yes** __________ **No** __________

Maternity coverage **Yes** __________ **No** __________

*Note: If you select Maternity Coverage, the Three year Rate Lock will be added to your plan. There is a 3 month waiting period if you are not pregnant at the time of application.

If yes, please select the deductible and maximum coverage you want for the maternity coverage:

Deductible for Maternity Coverage: ______________________________

Total Policy Year Maximum for Maternity Coverage: ______________________________

Three Year Rate Lock: **Yes** __________ **No** __________

Requested Effective Date (at least 14 days after date of application): __________ __________ __________

Month **Day** **Year**

Premium Mode: __________ __________ __________ __________

Monthly **Quarterly** **Semi-annual** **Annual**

Is this policy being applied for intended to replace any other insurance? **Yes** __________ **No** __________

If yes, type of coverage(s) ______________________________

Policy Number(s) ______________________________

Company(ies) ______________________________

ACCOUNT INFORMATION FOR PREMIUM PAYMENTS

Please choose one method of payment for your premiums. You may change your choice at any time through the Portal. You can also change it by calling the Program Administrator ("Admin") at the toll-free number 1-877-653-6440.

◯ Option #1: Automatic Credit Card Payment

Cardholder's Name ______________________________

Card Number ____________________ Card Type ____________________

Expiration Date __________ CVV # ______________ Billing Zip Code __________

OR

◯ Option #2: Electronic Funds Transfer via Bank Account

Financial Institution Name ______________________________

Checking Account ____________________ Savings Account ____________________

Routing Number ____________________ Account Number ____________________

OR

◯ Option #3: Paying by Check via the Mail

If I have selected Option 1 or Option 2, I hereby authorize the Admin to debit entries from the card/bank account listed above to pay for my premium amounts.

Cardholder/Accountholder Signature ____________________ Date ______________

ACCOUNT INFORMATION FOR PAYMENT OF MY PORTION OF MEDICAL INVOICES

Please choose one method of payment for your part of any Medical Invoice. You may change your choice at any time through the Portal. You can also change it by calling the toll-free number 1-877-653-6440.

◯ Option #1: Use the same payment elections for paying my portion of medical invoices as I have selected above for paying my premiums.

OR

◯ Option #2: Automatic Credit Card Payment

Cardholder's Name ______________________________

Card Number ____________________ Card Type ____________________

Expiration Date __________ CVV # __________ Billing Zip Code __________

OR

◯ Option #3: Electronic Funds Transfer via Bank Account

Financial Institution Name ______________________________

Checking Account ____________________ Savings Account ____________________

Routing Number ____________________ Account Number ____________________

OR

◯ Option #4: Paying by Check via the Mail

If I selected Option 1, Option 2 or Option 3, I hereby authorize the Admin to debit entries from the card/bank account listed above to pay for my portion of any Medical Invoice. In such case, I understand and agree that my card/bank account will be linked to the debit card provided to me by the Admin for the payment of my portion of any Medical Invoice.

Cardholder/Accountholder Signature ____________________ Date ____________________

APPLICANT'S ACKNOWLEDGEMENTS

I have read and agree to the statements above and confirm that all the information I have provided is true and complete to the best of my knowledge.

I understand that my use of this policy is administered by the Admin, Sidecar Health Insurance Solutions, LLC. I understand that I may access information about this policy through a website, web-based application, or other digital platform identified by the Admin. I also understand that any benefits that are paid under this policy will be delivered via a debit card issued to me by the Admin unless I request to receive such benefits in the form of a paper check sent to me via the mail.

I understand that my policy will only cover services that are deemed Medically Necessary. I also understand that should I feel that a claim has been wrongly denied, I can file an appeal under state laws.

The Portal is not a part of the Policy. It is offered to provide information only. If there is any conflict in language between the Policy and the Portal, the Policy language will control.

I understand this policy does not provide comprehensive medical insurance coverage as defined by the Affordable Care Act. I understand that this policy is a supplement to health insurance and is not a substitute for comprehensive medical insurance. I also understand that lack of comprehensive medical insurance (or other minimum essential coverage) may result in an additional payment with my taxes.

I understand that any person who knowingly makes a false or fraudulent claim for payment of a loss or benefit or knowingly states false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I acknowledge that I have received and understand the terms and conditions provided to me at the time I applied for this coverage.

By signing this application, I represent and warrant that I will take full responsibility for payments should the account become delinquent or there is evidence of fraud.

Signature of Insured or Guardian (if Insured is under 18) ______________________________

Print Name ______________________________ Date ______________

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

APPLICANT'S AUTHORIZATIONS

I hereby permit any licensed physician, health care professional, hospital, clinic, Veterans Administration or other medical facility, care provider, pharmacy or pharmacy benefit management (PBM) company, any prescription database service, insurance company, consumer reporting agency, administrative services provider or insurance support company that has any records or knowledge of my health, drug or medication history to give to the Company, and agents acting for the Company including its employees, third-party administrative services provider, insurance support organizations, or its reinsurer(s) any such information ("Health Data"). Such Health Data about me may be disclosed to the Company and any representatives acting for the Company, including its agents, insurance support organizations, third-party administrators, affiliates, any reinsurers, and any consumer reporting agency.

I recognize that such Health Data will be used to consider my insurability with the Company, for claims and payment processing and for other permitted uses in accordance with the HIPAA Privacy Rule. A photocopy of this permission will be as valid as the original. I agree that this permission will be valid for 24 months from the date signed. This permission may be revoked by submitting a written request to the Company's Privacy Office to: 5 Christopher Way, Eatontown, NJ 07724. Any action taken by the Company (or one of its agents) before the receipt of such notice of revocation will still be valid.

Although my signature on this form is voluntary, I understand that it is required to determine my insurability and qualification to be issued an insurance policy from the Company. Without my signature, I understand that my application for insurance cannot be processed. By signing, I also acknowledge that if a party or organization receiving my Health Data is not a health plan or health care provider subject to federal health information privacy laws, then the information described may be disclosed to others and may no longer be protected by such laws. However, the Company does require its agents to keep the confidentiality of Health Data.

______ By initialing here and signing below, I further authorize the Company, directly or through its Admin, to use my Health Data in order to include me on Company or Admin mailing lists and other forms of marketing communications from the Company, the Admin, and the Company's other agents that will identify programs and provide other information that may interest me. Neither the Company nor the Admin receives any remuneration from third parties for such marketing communications, and neither the Company nor the Admin will provide any of my Health Data to unrelated parties for their own marketing. Initialing this section is entirely voluntary, and my decision to allow or prohibit marketing communications from the Company or the Admin will not affect the Company's determination regarding my insurability and/or qualifications to be issued an insurance policy.

I understand that a copy of this signed permission form will be given to me or my authorized agent. No producer can waive or change any receipt or policy provision or agree to issue a policy.

Signature: ______________________________ Date: ______________

APPLICANT'S CONSENT TO ELECTRONIC DELIVERY

The Company may not communicate with you by electronic means unless you give consent.

☐ I give my written consent to allow the Company to communicate with me, either directly or indirectly through the Admin, by email to the address listed in the application. I confirm that I am authorized to provide consent for email to the email address that I provided and further agree to indemnify and hold harmless the Company for any action or loss arising from any incorrect or false email address provided.

I acknowledge that, should I desire to revoke this written authorization, I will inform the Company in writing.

Signature: ______________________________ Date: ______________

Note: If you elect to allow for notices and communications to be sent to the email address you provided, you should know that the Company considers this election to be consent by you that all notices may be sent electronically. This consent includes notice of termination and notice of cancellation. As a result, you should be diligent in electronically notifying the Company and updating the email address you provided to the Company if the address should change. However, you may notify the Company in writing, at the Company's Administrative Office or electronically, if you prefer to withdraw this Consent to Electronic Delivery. If you withdraw this Consent to Electronic Delivery, then effectively immediately, the Company will no longer provide electronic notices and communications to you, and instead such communications will be provided in paper form to your address that is on file with the Company.

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS.

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- Any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Hospice care
- Other approved items and services

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.
✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

"A Guide to Health Insurance for People with Medicare" is available at
https://www.medicare.gov/Pubs/pdf/02110-medicare-medigap-guide.pdf