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 _____ _____ **DATE OF BIRTH** _____ _____ _____
Male Female Month Day Year

EMAIL _____

ADDRESS _____ _____ GA _____
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?

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 form **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