UNITED STATES FIRE INSURANCE COMPANY

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

APPLICATION FOR FIXED INDEMNITY INSURANCE

The 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, the policy is not subject to the ACA requirements for comprehensive health insurance coverage. The policy provides limited benefits and DOES NOT provide "minimum essential coverage" or "essential health benefits."

NAME ______________________ ______________________
First Last

SEX ________ ________ **DATE OF BIRTH** ________ ________ ________
Male Female Month Day Year

EMAIL ____

RESIDENCE ADDRESS ______________________ ____________ TX ________
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 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 ________

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 200 lbs. as a female — Yes ________ No ________

Have you visited any of the following five or more times in the past 12 months?

Chiropractor — Yes ________ No ________

Psychiatrist or Psychologist — Yes ________ No ________

Are you currently:

Fighting cancer or in cancer remission — Yes ________ No ________

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

Pregnant — Yes ________ No ________

Using tobacco products once or more daily — Yes ________ No ________

What procedures do you expect to have in the next 12 months?

____

What prescriptions do you take regularly?

____

Covered Percentage ________ 80% ________

Deductible ____

Total Policy Year Maximum ____

Outpatient Prescription Drug — Yes ________ No ________

Three Year Rate Lock — Yes ________ No ________

Requested Effective Date ________ (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 monthly premiums. You may change your choice at any time through the Sidecar Health Portal. You can also change it by calling Sidecar Health Insurance Solutions, LLC (including its affiliates and subsidiaries, collectively "Sidecar Health") at the toll-free number 1-877-653-6440.

◯ Option #1: Automatic Credit Card Payment

Cardholder's Name ____________________

Card Number ____________________ Card Type ____________________

Exp 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 Sidecar Health 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 Sidecar Health 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 ______________________

Exp 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 Sidecar Health 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 Sidecar Health for the payment of my portion of any Medical Invoice.

Cardholder/Accountholder Signature ______________________ Date ______________

APPLICANT'S STATEMENTS AND AGREEMENTS

The policy provides limited benefits. Review your policy carefully. The Company may cancel the policy at any time unless you have purchased the Three Year Rate Lock and/or upon your renewal date. If this policy is cancelled or if you reach the benefit limits, you may not be able to buy ACA coverage on HealthCare.gov until open enrollment.

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 Sidecar Health. I understand that I may access information about this policy through a website, web-based application, or other digital platform identified by Sidecar Health. I also understand that any benefits that are paid under this policy will be delivered via a debit card issued to me by Sidecar Health 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 Sidecar Health Portal and Navigation Tool 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 Sidecar Health Portal and Navigation Tool, 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.

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.

CONSENT TO ELECTRONIC DELIVERY

United States Fire Insurance Company (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 Sidecar Health, 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 and Sidecar Health 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 and Sidecar Health in writing.

Signature: ______________________________ Date: ________________

Note: The applicant electing to allow for notices and communications to be sent to the electronic mail address provided should be aware that the Company rightfully considers this election to be consent by the applicant that all notices may be sent electronically. This consent includes notice of non-renewal and notice of cancellation. As a result, the applicant should be diligent in electronically notifying the Company and updating the electronic mail address provided to the Company if the address should change. However, the applicant may notify the Company in writing, at the Company's Administrative Office or electronically, if the applicant prefers to withdraw this Consent to Electronic Delivery. If this Consent to Electronic Delivery is withdrawn, effectively immediately, the Company will no longer provide electronic notices and communications to the applicant, and instead such communications will be provided in paper form to the 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