

# Special Insurance Services (SIS)

## Hospital GAP PLAN<sub>o</sub> Coverage Verification

This form is to be completed by the employer and the agent in order to provide proof of in-force medical coverage offered by the employer. All information must be completed in order for business to be processed.

I understand that the policy that I have selected is the Hospital GAP PLAN<sub>o</sub> Insurance Policy. It is a supplemental limited benefit policy that covers many of the out-of-pocket hospital expenses, but will not cover 100% of out-of-pocket expenses. This policy is intended to supplement a major medical/comprehensive medical policy with managed care. While benefits are not coordinated with the major medical/comprehensive medical policy, the Hospital GAP PLAN<sub>o</sub> policy cannot be issued unless each eligible insured is covered under a group major medical/comprehensive medical policy with managed care. CHAMPUS/TRICARE and/or Medicaid are not considered major medical/comprehensive medical plans.

Any changes to my major medical/comprehensive medical policy, such as increasing the deductible or participating in a Health Maintenance Organization or Preferred Provider Organization, will require me to take a second look at this policy and see if it still meets my needs.

If I discontinue offering major medical/comprehensive medical coverage, I will need to discontinue the Hospital GAP PLAN<sub>o</sub> as well.

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**Signature**

(Must be signed by an owner/officer authorized to make a legally binding decision for the employer)

**Major Medical/Comprehensive Medical Plan**

*Only one Hospital GAP PLAN<sub>o</sub> may be offered unless your medical plan offers various deductible and co-payment options.*

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**Printed Name**

Please complete the following:

**Deductible:** \$ \_\_\_\_\_  
**Total Out-of-Pocket Maximum:** \$ \_\_\_\_\_  
**Hospital GAP PLAN selected:** \$ \_\_\_\_\_

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**Title (Please Print)**

If more than one GAP PLAN<sub>o</sub> is selected, please complete the following:

**Deductible:** \$ \_\_\_\_\_  
**Total Out-of-Pocket Maximum:** \$ \_\_\_\_\_  
**Hospital GAP PLAN selected:** \$ \_\_\_\_\_

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**Name of Firm (Please Print)**

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**Date**

*It is recommended that the Hospital GAP PLAN<sub>o</sub> plan maximum per hospital confinement be at least 100% of the underlying medical plan deductible.*

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**Agent Signature/Agent Number**

*At no time should the Hospital GAP PLAN<sub>o</sub> plan maximum exceed the Total Out-of-Pocket maximum.*

