

About the Insurance Company

Liberty STM, under Policy Series STP-03 is underwritten by The Chesapeake Life Insurance Company (a UICI Company). Founded in 1956, The Chesapeake Life Insurance Company has protected millions of insureds and earned an "A-" (Excellent) rating from A.M. Best Company.

About the Administrator

HPA is a fully licensed, full-service Third Party Administrator transacting business worldwide. Established in 1939, HPA is a third generation company providing state-of-the-art industry leading insurance services, including customer service, claims payment, billing and reporting. HPA's specialty products division was founded by Michael Kosloske who now serves as company president.

This brochure provides general information about the Liberty Short Term Medical Insurance Plan.

It is not a contract. The complete terms, provisions and conditions of coverage are described in the Policy/Certificate issued by The Chesapeake Life Insurance Company and may vary by state.

Featuring
Daily Rates

HPA

The Competitor

Liberty STM

Short Term Medical Insurance

THE IDEAL SOLUTION FOR

- People between jobs
- New employee waiting periods
- Part-time or temporary employees
- Dependent child coverage
- College students or new graduates

SPECIAL FEATURES

- Choose coverage for 30 to 180 days
- Convenient monthly pay option
- Freedom to choose any doctor or hospital
- Child only coverage available
- Maximum of three deductibles per family



Underwritten by:
The Chesapeake Life Insurance Company,
a UICI Company Rated A- (Excellent) by A.M. Best Reports
Administered by: Health Plan Administrators, Inc., Rockford, IL
Marketed by:

What is Liberty STM?

Just because you don't have health insurance right now doesn't mean you won't have health problems. Liberty STM allows you and your family to purchase high quality and affordable medical coverage. You can choose to prepay for 30 days to 180 days or pay by monthly installments. Coverage is provided for physician services, surgery, prescription drugs, outpatient and inpatient care.

How benefits are covered?

The benefit options for covered expenses for injury or sickness per insured person per benefit period.

First, you meet your deductible. Choose from five options:
\$250, \$500, \$1,000, \$2,000 or \$5,000

Then Liberty STM pays the coinsurance for the covered expenses: 80% up to \$10,000.

After this, Liberty STM pays 100%
of covered expenses up to your maximum of \$1 million per insured

Who is eligible to apply?

You and your spouse (to 64 years and 11 months old) and your unmarried dependent children* (between age 15 days to 19 years old, or 23 years old if a fulltime student) can apply for coverage provided they are in good health and: 1) will not have other hospital, major medical, health, governmental, or medical insurance coverage in force that will not terminate prior to the Effective Date; 2) have not been declined for insurance due to health reasons; 3) are not pregnant or the expectant father of an unborn child on the Effective Date; 4) have reached the age of 15 days and will be under age sixty-five (65) on the Termination Date; 5) are not to be Foreign visitors, non-US citizens or persons traveling outside the United States of America; and 6) have not received consultation or treatment within the past five years for any condition identified on the application.

* Newborn and adopted to the insured while covered, are covered for the first 31 days. Additional premium and application is required to continue coverage.

When does my coverage start?

Your coverage begins at 12:01 a.m. (where you live) on the Policy date listed on the application or the day after the postmark date on your application envelope, whichever is later. If your envelope is not postmarked by the U.S. Postal Service or the postmark is illegible, your Policy date will be the later of the date you request or the date HPA, Inc. receives the application.

What medical expenses are covered?

Inpatient (No Pre-certification is required):

- Room and board
- Hospital miscellaneous expenses
- Intensive care
- Physiotherapy
- Surgery
- Assistant Surgeon
- Anesthetist up to 25% of surgery allowance
- Registered Nurse
- Physician's visits
- Pre-admission testing

Outpatient Treatments:

- Surgery
- Hospital miscellaneous expense
- Anesthetist up to 25% of surgery allowance
- Physician's visits
- Physiotherapy
- Medical emergency
- X-rays and laboratory tests
- Radiation therapy
- Tests and procedures
- Injections
- Chemotherapy
- Prescription drugs up to \$500 maximum

Other Services:

- Ambulance - Ground transportation only*
- Durable medical equipment
- Consultant
- Dental - Benefits are paid for Injury to Sound, Natural teeth only

* In Arizona the most available and necessary ambulance service is covered.

Detailed information about these and additional Covered Expenses are listed in the Policy. Not all covered expenses apply in every state, and additional expenses might be covered in your state. Consult the Certificate / Policy for provisions in your state.

What is a usual and customary charge?

This plan provides benefits based on Usual and Customary Charges, defined as the lesser of: 1.) the actual charge; 2.) what the provider would accept for the same service or supply in the absence of insurance; or 3.) the reasonable charge as determined by the Company, based on factors such as: a.) the most common charge for the same or comparable service or supply in a community similar to where the service or supply is furnished; b.) the amount of resources expended to deliver the treatment rendered; or c.) charging protocols and billing practices generally accepted by the medical community or specialty groups; or d.) inflation trends by geographic location.

When does coverage terminate?

Coverage will terminate on the earlier of: 1.) the Benefit Period termination date; 2.) the last day of the period through which the plan cost is paid; 3.) the date the Insured Person attains age 65 or becomes Medicare eligible; or 4.) if a dependent child, the date on which his/her eligibility terminates.

Can I continue coverage?

Liberty STM is issued on a temporary need and terminates at the end of the period applied for. If the need for temporary health insurance continues, you may apply for another new STM* coverage period. Your application is subject to the eligibility and underwriting requirements. Furthermore the coverage is not continuous. Any condition that incurred expense during the last coverage period will be treated as a Pre-Existing Condition, and be excluded under the next coverage period. Applicants over the age of 64 are not eligible to re-apply for coverage.

*Please note: The total amount of coverage can not exceed the maximum of 180 days in Minnesota, 363 days in Utah and you cannot reapply for coverage in Georgia, Idaho or Oregon.

What is a Family Deductible?

With the **Family Deductible** benefit, your insured family is only required to satisfy three (3) deductibles during the benefit period.

Is there a free look period?

Once you receive your Certificate / Policy, carefully review all information. If you are not satisfied for any reason, return the Certificate / Policy (within 10 days of receipt) with your written request for cancellation to HPA. Coverage will be cancelled as of the effective date and you'll receive a full refund (less the administration fee) — no questions asked.

Is there a Pre-Existing Condition limitation?

Yes, Pre-Existing Conditions are not covered. A Pre-Existing Condition means 1.) the existence of symptoms within the five (5) years immediately prior to the Insured's Effective Date or, 2.) any condition which originates, is diagnosed, treated, or recommended for treatment or for which medication was prescribed or recommended within the five (5) years immediately prior to the Insured's Effective Date.

Is there coverage after termination?

If an Insured incurs medical expenses after the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues: 1.) When Hospital Confined on the Termination Date, not to exceed 90 days after the Termination Date; or 2.) When not Hospital Confined on the Termination Date, not to exceed 30 days after the Termination Date. The Insured Person must: a.) have met his or her Deductible during the Benefit Period; and b.) be being treated for complications of or follow-up treatment for an Injury or Sickness which commenced during the Benefit Period.

The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the Maximum Benefit. After this "Extension of Benefits After Termination" provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

How do I apply?

To apply for Liberty STM insurance, simply:

- 1.) Complete and sign the attached application.
- 2.) Attach a check in the amount of the total premiums and fees for the coverage you've selected. No check is needed if payment by credit card.
- 3.) *Mail the completed application and payment to:

Health Plan Administrators, Inc.
P.O. Box 15250
Rockford, IL 61132-5250
www.hpa-inc.com

1-800-277-3323

*If payment by credit card, you can fax the completed and signed application toll free to: 1-888-FAX-HPA1

What are the plan exclusions and limitations?

Unless specifically listed as a Covered Expense in the Policy (or as may be provided by an Amendment Rider), no benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from: or b) treatment, services or supplies for, at or related to: Pre-Existing Conditions, as defined in the policy;

- Addiction and codependency;
- Acne; acupuncture;
- Allergy, allergy testing; alopecia;
- Autistic disease of childhood, hyperkinetic syndromes, milieu therapy, learning disabilities, behavioral problems, parent-child problems, attention deficit disorder, conceptual handicap, developmental disorder or mental retardation;
- Biofeedback;
- Chronic Pain;
- Complications of any treatment or surgery that is excluded;
- Congenital conditions;
- Circumcision;
- Cosmetic; hirsutism; warts, nonmalignant moles and lesions;
- Dental Benefits are paid for injury to sound, natural teeth only;
- Custodial care;
- Elective Surgery/Treatments, elective abortion;
- Expenses incurred outside of the United States, its possessions, territories or Canada;
- Foot care;
- Health spa;
- Hearing examinations and aids;
- Hypnosis
- Immunizations, preventive medicines or vaccines;
- Injury caused or contributed by addiction or use of alcohol, intoxicants, hallucinogenics, illegal drugs, or medicines that are not taken as prescribed by a Physician;
- Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
- Benefits payable by Medicare or any other government law or program (except Medicaid); or medical coverage under any automobile insurance;
- Injury sustained while (a) participating in any intercollegiate, international or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;
- Lipectomy;
- Mental and Nervous Disorders;
- Motor vehicle Injury in excess of \$2,000;
- Normal pregnancy;
- Organ transplants;
- Participation in a riot or civil disorder; commission of or attempt to commit a felony or fighting;
- Prescription Drug, services or supplies as follows: a) *Therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use; b) Contraceptives; c) Immunization agents, biological sera, blood or blood products administered on an outpatient basis; d) Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs; e) Cosmetic products; f) Drugs to cure or treat baldness,

Exclusions and limitations continued

and anabolic steroids used for body building; g) Anorectics - drugs used for the purpose of weight control; h) Fertility or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra; i) Growth hormones; or j) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription;

- Private duty nursing;
- Rehabilitation Services;
- Reproductive and Infertility services;
- Research studies
- Routine Newborn Infant Care, well-baby nursery and related Physician charges in excess of 48 hours for vaginal delivery or 96 hours for cesarean delivery;
- Routine physicals, testing or screening in the absence of Injury or Sickness;
- Sclerotherapy;
- Services or supplies from your immediate family;
- Skeletal irregularities of jaw, temporomandibular joint dysfunction, including orthognathia and mandibular retrognathia; deviated nasal septum, sub-mucous resection; nasal and sinus surgery;
- Injuries sustained from skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in an aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
- Sleep disorders;
- Suicide or attempted suicide; or intentionally self-inflicted Injury;
- Surgery to the Breast for reduction, augmentation, implants, prosthetic devices or gynecomastia;
- Taxes; provider administrative expenses; travel, transportation or living expenses;
- Injuries sustained from Motorcycle, recreational vehicle; including but not limited to two or three wheeled motor vehicle, four wheeled all terrain vehicle (ATV), jet ski, ski cycle, snowmobile, skiing, scuba diving, surfing, roller skating, riding in a rodeo;
- Treatment in a Government hospital;
- Tonsils or adenoids;
- Vision services and supplies
- War or any act of war, declared or undeclared; or while in the armed forces of any country; and
- Weight management, obesity, surgery for removal of excess skin or fat or eating disorders such as bulimia and anorexia.
- Knee injury treatment, services or supplies are limited to a maximum of \$1,500 per person per certificate/policy.
- Gall bladder surgery is limited to a maximum of \$1,500 per person per certificate/policy.

Detailed information about these and other plan limitations and exclusions are listed in the Policy and may vary by state. **The Policy is deemed amended to conform to the minimum requirements of the laws of the state in which coverage is issued.**

**Except in Arizona when prescribed for the treatment of Diabetes.*



Liberty STM (Generic)
The Chesapeake Life Insurance Company
Short Term Medical Insurance Application
THIS POLICY IS NON-RENEWABLE

COMPLETE THE COVERAGE INFORMATION

A. Requested Effective Date (choose one)*

Day after US Postmark Stamp
 Later requested effective date: _____
 *Coverage cannot be effective prior to termination of any other insurance coverage in force, before the date the application is signed or more than 30 days after application is signed.

B. Deductible per Person (choose one)

\$250 \$500 \$1,000 \$2,000 \$5,000

C. Select Benefit Period (choose one)

30 Days 60 Days 90 Days
 120 Days 150 Days 180 Days
 Enter number of days # _____ Number of days, must be at least 30 days, no more than 180 days.

D. Payment Options (choose one)

Monthly Pay Single Pay

E. Payment Method (choose one)

Check/Money Order Credit Card
 Monthly Automatic Bank Withdrawal

INSURED'S NAME (Print last, first, Middle) _____ SEX _____ BIRTHDATE (M-D-Y) _____ SOCIAL SECURITY NUMBER _____

RESIDENCE / STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

MAILING ADDRESS (IF DIFFERENT FROM PERMANENT ADDRESS ABOVE) _____

PHONE NUMBER _____ E-MAIL ADDRESS _____

SPOUSE'S NAME (If to be insured) _____ SEX _____ BIRTHDATE (M-D-Y) _____ SOCIAL SECURITY NUMBER _____

1) CHILD NAME (Full name if to be insured) _____ BIRTHDATE (M-D-Y)* _____ 2) CHILD NAME (Full name if to be insured) _____ BIRTHDATE (M-D-Y)* _____

3) CHILD NAME (Full name if to be insured) _____ BIRTHDATE (M-D-Y)* _____ 4) CHILD NAME (Full name if to be insured) _____ BIRTHDATE (M-D-Y)* _____

*Must be at least 15 days old to apply

ANSWER THE FOLLOWING QUESTIONS COMPLETELY AND ACCURATELY:

- Do you or any applicant to be insured have any hospital, major medical, group health, government or medical insurance coverage in force that will not terminate prior to the effective date of this coverage? Yes No
- Are you, your spouse, or any dependent, (whether listed on the application or not) now pregnant, or are you an expectant father of any unborn child? Yes No
- Have you or any person to be insured been declined for insurance due to health reasons? Yes No
- Have you or any person to be insured, in the past five years, received any treatment, medication, or medical or surgical advice for heart or circulatory system disorder, including heart attack or chest pain, stroke, diabetes, cancer or tumor, leukemia or blood disorder, alcohol or drug abuse or dependency, immune system disorder or been tested positive for exposure to the HIV (Human Immune Deficiency) infection or been diagnosed by a physician as having ARC (Aids Related Complex) or AIDS (Acquired Immune Deficiency Disorder) caused by the HIV infection or other sickness or condition derived from such infection? ... Yes No

NOTE: The plan cannot be issued if YES is answered on any of the above questions.

READ AND SIGN THE AGREEMENT:

I have read this application and represent that each of the above statements and answers are complete and true to the best of my knowledge and belief, and I understand that the answers to the above questions shall be the basis of any coverage issued, and that any untrue answer may operate to void this coverage.

Any material misstatement or omission of information made on this form will be considered a misrepresentation and may be the basis of claim denial or later rescission of coverage issued on the basis of the above information. Such rescission and termination of coverage will apply to the Named Insured and his or her Dependents without liability to the Company. Coverage is not effective until approved and issued by The Chesapeake Life Insurance Company.

I understand that the Company will not pay benefits during the term of coverage for loss due to any medical condition or illness I or any person to be insured may now have or had.

I hereby authorize any insurance company, organization, employer, hospital, physician, pharmacist, educational institution, or other person to release to the Company such information as it may require to process claims.

Louisiana Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

New Mexico Residents: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Ohio Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

RIGHT TO EXAMINE COVERAGE FOR 10 DAYS: If the Named Insured is not satisfied, return the certificate or policy to the Company within 10 days after it is delivered. All premiums will then be refunded. If returned, coverage shall be void from the beginning. The parties shall be in the same position as if no coverage had been issued.

NO RECOVERY FOR PRE-EXISTING CONDITIONS: - No benefits will be provided during the term of the Policy for any Pre-existing Condition as defined in the Certificate or Policy.

APPLICANT SIGNATURE _____ DATE _____

stp-ea(3)

CREDIT CARD PAYMENT REQUEST:

I authorize Health Plan Administrators, Inc. to charge my credit card premium and fees once for Single Pay Option; or the 1st month and each month thereafter for the Monthly Pay Option.

VISA MC DISCOVER CARD

ACCOUNT NUMBER _____ EXP. DATE _____

PRINT ACCOUNT HOLDERS NAME (As it appears on the card.) _____

SIGNATURE OF CARDHOLDER _____ DATE _____

IF PAYMENT BY CHECK/ MONEY ORDER :

MAKE CHECK PAYABLE AND MAIL TO HEALTH PLAN ADMINISTRATORS, INC. 15436 N. FLORIDA AVE, STE 105 TAMPA, FL 33613

AUTOMATIC CHECK WITHDRAWAL REQUEST:

By selecting automatic check withdrawal, your Chesapeake Life Insurance Company monthly premium and fees will automatically be withdrawn from your checking account until the term of insurance expires. **Complete the form below. Attach a voided check and a check for the first month premium and fees.**

PRINT NAME OF BANK OR INSTITUTION _____

ADDRESS OF BANK OR INSTITUTION _____

I request that you pay and charge my account debits drawn from my account by Health Plan Administrators, Inc. to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may at any time, end this agreement by giving 30 days advanced written notice to me and to Health Plan Administrators, Inc. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

SIGNATURE OF PREMIUM PAYER _____ DATE _____

FOR AGENTS USE ONLY:

Include a current copy of your license and the completed HPA License Request Form with your 1st application.

AGENTS FULL NAME _____

SOCIAL SECURITY # _____ HPA # _____

ADDRESS _____

CITY _____ ST _____ ZIP CODE _____

PHONE # _____ FAX # _____ E-MAIL _____

GA NAME _____ HPA # _____

ADDRESS _____ CITY _____ ST _____ ZIP CODE _____

PHONE # _____ FAX # _____

MGA NAME _____ HPA # _____

PHONE # _____ FAX # _____



LIBERTY STM RATES (Effective 2/1/05)

Daily and Monthly Rates are for the 80% / 20% Coinsurance up to \$10,000
(Locate your rates based on the Benefit Period and Deductible Option you selected on the application.)

DAILY RATES - 30 TO 180 DAYS
(USE FOR SINGLE PAY OR MONTHLY PAY UP TO 6 MONTHS)

Deductible	\$250	\$250	\$500	\$500	\$1,000	\$1,000	\$2,000	\$2,000	\$5,000	\$5,000
Age	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-29	2.05	2.51	1.62	2.00	1.28	1.57	0.91	1.11	0.74	0.88
30-34	2.74	3.42	2.19	2.74	1.71	2.11	1.23	1.51	0.97	1.23
35-39	3.42	4.42	2.74	3.53	2.11	2.74	1.51	1.97	1.23	1.57
40-44	4.33	5.16	3.45	4.10	2.68	3.19	1.91	2.28	1.54	1.82
45-49	5.70	5.93	4.56	4.73	3.53	3.68	2.54	2.62	2.02	2.02
50-54	6.61	6.84	5.27	5.44	4.10	4.25	2.94	3.02	2.34	2.34
55-59	9.12	8.44	7.27	6.73	5.67	5.24	4.05	3.73	3.22	3.22
60-64	13.22	11.17	10.55	8.92	8.21	6.93	5.87	4.96	4.67	4.67
Per Child	1.82	1.82	1.45	1.45	1.14	1.14	0.80	0.80	0.66	0.66

INSTRUCTIONS FOR CHILD ONLY COVERAGE

The minimum is 15 days old for child only coverage. Use the 0-29 monthly rate for either the male or female, based on the gender of the oldest child; then use the per child rate for each of the other siblings to be insured. The parent or legal guardian must sign and date the application.

**ABOUT THE UNITED CONSUMERS SAVINGS ASSOCIATION
DISCOUNT PLUS CARD (UCSA)**

The UCSA Discount Plus Card provides money saving discounts for: Retail cost of prescription drugs; Dental services; Eye and vision care; Chiropractic services; Vitamin & Nutritional supplements; 24 Hour Nurse Help Line; Accudiet.com, an on-line interactive exercise and diet program; National Health Survey, discounts for Health & Lifestyle Assessment. The UCSA Discount Plus Card fulfillment kit is mailed to you automatically after payment of the first dues is received.

The UCSA Discount Plus Card cost is \$12.50 per month or \$.42 cents per day. The UCSA Discount Plus Card not affiliated with The Chesapeake Life Insurance Company, nor is it a part of the insurance plan.

PAYMENT BY CHECK OR MONEY ORDER

Make the check/money order payable to:
HEALTH PLAN ADMINISTRATORS, INC.

Mail your completed application to the address listed on the brochure.
If none is listed mail to:

HPA, INC.
15436 N. FLORIDA AVE, SUITE 105
TAMPA, FL 33613

SAVE TIME AND POSTAGE

If you pay by credit card, simply fax both sides of the completed, signed and dated application toll free to: **1-888-329-4721**

STATE, ZIP CODE & RATE AREA FACTOR CHART

1. Locate your resident state and zip code on the chart below. Your premium area factor is listed to the right.
2. Enter your premium area factor in # 5 on the Rate Calculation Instructions.

State	Zip Prefix	Area Factor	State	Zip Prefix	Area Factor
Alabama			Nebraska		
351.....		1.15	680, 681, 683, 684.....		0.88
352, 354.....		1.07	685, 690, 692, 693.....		0.88
350, 355, 357, 360, 361.....		1.00	All other.....		0.82
362, 364, 365, 369.....		1.00	Nevada (Use NV application)		
All other.....		0.93	New Hampshire (Use NH application)		
Alaska All zips.....		1.23	New Mexico All zips.....		0.88
Arizona			North Carolina (Use NC application)		
850, 852.....		1.15	North Dakota (Use ND rates & application)		
853.....		1.07	Ohio		
All other.....		1.00	441, 440.....		1.07
Arkansas (Use AR application)			434, 442, 443, 446.....		0.93
California (Use CA application)			447, 450, 451, 452.....		0.93
Colorado (Use CO application)			430, 431, 432, 433.....		0.88
Connecticut (Use CT application)			435, 436, 439, 444.....		0.88
Delaware All zips.....		0.93	445, 448, 449, 453.....		0.88
DC All zips.....		1.15	454, 455, 457, 459.....		0.88
Florida (Use FL application)			437, 438.....		0.82
Georgia (Use GA application)			All other.....		0.74
Hawaii All zips.....		1.00	Oklahoma		
Idaho (Use ID application)			730, 731, 734, 736.....		0.88
Illinois			738, 739, 743, 744.....		0.88
606, 608.....		1.23	745, 746, 747, 748, 749.....		0.88
602, 603, 607.....		1.15	All other.....		0.82
600, 601, 604, 605.....		1.07	Oregon (Use OR application)		
609, 611, 613, 614.....		0.88	Pennsylvania		
615, 616, 618, 619.....		0.88	191.....		1.39
620, 622, 623, 627.....		0.88	190.....		1.29
617.....		0.82	151, 152, 189, 193.....		1.23
All other.....		0.74	150.....		1.15
Indiana (Use IN application)			153, 154, 164, 165, 166.....		1.07
Iowa			180, 181, 182.....		1.07
503.....		0.88	155, 156, 157, 159, 160.....		1.00
502, 504, 505, 506.....		0.82	161, 162, 163, 167, 168.....		1.00
508, 509, 510, 512.....		0.82	171, 172, 173, 175, 176.....		1.00
513, 516, 520, 521.....		0.82	177, 178, 179, 183, 184.....		1.00
522, 523, 524, 527, 528.....		0.82	185, 186, 187, 188, 195.....		1.00
All other.....		0.75	196.....		1.00
Kansas (Use KS rates & application)			All other.....		0.93
Kentucky			Rhode Island All zips.....		0.82
401, 402, 403, 404, 406.....		0.94	South Carolina All zips.....		0.88
411, 412, 421, 422.....		0.94	South Dakota (Use SD rates & application)		
405, 407, 408, 409, 410.....		0.88	Tennessee		
413, 414, 415, 416, 417.....		0.88	372, 374, 375, 381.....		1.00
418, 424, 425, 426, 427.....		0.88	371, 379.....		0.94
All others.....		0.82	376, 380, 382, 384-385.....		0.88
Louisiana			All.....		0.82
700.....		1.15	Texas (Use TX application)		
701, 703, 707, 708.....		1.07	Utah		
704, 710-712, 714.....		1.00	841, 846.....		0.88
705.....		0.93	840.....		0.82
All others.....		0.88	All other.....		0.74
Maine (Use Maine application)			Virginia (Use VA application)		
Maryland (use MD application)			Washington (Use WA rates & application)		
Michigan (12 Month STM not available.)			West Virginia		
482.....		1.15	250, 251, 252, 253, 260.....		0.88
480, 481, 483.....		1.07	247, 248, 249, 254, 255.....		0.82
484, 485.....		0.93	256, 257, 258, 259, 261.....		0.82
486, 487, 488, 489, 490.....		0.88	262, 263.....		0.82
491, 493, 494.....		0.88	264, 266, 267, 268.....		0.82
All other.....		0.82	All other.....		0.74
Minnesota (Use MN application)			Wisconsin (Use WI rates & application)		
Mississippi			Wyoming		
395.....		0.82	821, 826.....		0.82
All other.....		0.74	All other.....		0.74
Missouri (Use MO application)					
Montana (Use MT rates & application)					

PLAN AVAILABILITY

This plan is not available in MA, NJ, NY or VT. Please call HPA Sales Support for state forms and information: **1-800-277-3323, ext. 3**

LIBERTY STM RATE CALCULATION INSTRUCTIONS			Up to 6 Months (Use Daily Rates)	
			Single Pay	Monthly Pay
Complete the calculations based on the coverage and options you selected on the application.				
1.	Applicant:		\$	\$
2.	Spouse:		\$	\$
3.	Child:	Multiply (x) by the # ____ of children =	\$	\$
4.	Subtotal:		\$	\$
5.	State Zip Code Area Factor:	Multiply (x) by resident zip code area factor: ____ =	\$	\$
6.	Add the Discount Plus Card Dues:		\$0.42 (per day)	\$0.42 (per day)
7.	Subtotal:		\$	\$
8.	Single Payment:	Multiply (x) by # ____ of Days (Minimum 30) =	\$	NA
9.	Up to 6 Monthly Payments:	Multiply (x) by 30 days (Equals one month) =	NA	\$
10.	Add Monthly Administration Fee:		\$12.50	\$12.50
11.	Add Enrollment Fee:		\$10.00	\$10.00
12.	Final Total:		\$	\$