

APPLICATION FORM

Individual Solutions

This plan is underwritten by the Summa Insurance Company and administered by SummaCare. Failure to complete all sections may delay coverage date.

REQUESTED EFFECTIVE DATE OF COVERAGE: _____

Requesting an effective date does not guarantee that date. Underwriting must approve this application. No coverage comes into effect until it is approved by Summa Insurance Company and I am notified in writing.

INTERNAL USE ONLY

Actual Effective Date of Coverage: _____

Write in Plan Selected: _____

NAME

SOCIAL SECURITY NUMBER

MARITAL STATUS SINGLE MARRIED WIDOWED DIVORCED LEGALLY SEPARATED

ADDRESS NUMBER & STREET

CITY

STATE

ZIP CODE

COUNTY

HOME PHONE #

()

WORK PHONE #

()

EXT.

EMAIL ADDRESS

OCCUPATION

TYPE OF COVERAGE SELECTED (check one):

- FOR YOU ONLY FOR YOU PLUS YOUR SPOUSE FOR YOU PLUS YOUR CHILDREN
 FOR YOU PLUS YOUR SPOUSE AND CHILDREN FOR YOUR CHILD ONLY

- I AM APPLYING FOR NEW COVERAGE
 I AM AN EXISTING POLICYHOLDER APPLYING FOR A DIFFERENT POLICY
 I AM AN EXISTING POLICYHOLDER APPLYING TO ADD DEPENDENT(S) TO MY CURRENT POLICY
 I AM A FORMER MEMBER OF SUMMA INSURANCE COMPANY/SUMMACARE

COMPLETE THE FOLLOWING INFORMATION FOR ALL PERSONS TO BE COVERED .

IF THE ADDRESSES OF ANY OF THE FOLLOWING INDIVIDUALS ARE DIFFERENT FROM THE ADDRESS ABOVE, PLEASE LIST THE NAMES AND ADDRESSES ON A SEPARATE SHEET AND ATTACH THEM TO THE APPLICATION FORM.

IF YOUR DEPENDENT IS OVER THE LIMITING AGE BUT IS A FULL TIME STUDENT, *PLEASE ATTACH A CLASS SCHEDULE TO THIS APPLICATION AS PROOF OF STUDENT STATUS.*

Last Name	First Name	MI	Relationship (child/step/ other)	Social Security Number	Date of Birth (Mo/Day/Yr)	Sex (M/F)	Ht.	Wt.	Full Time Student (Y/N)

WILL YOU, YOUR SPOUSE, OR YOUR DEPENDENTS BE COVERED BY ANOTHER TYPE OF HEALTH INSURANCE WHILE COVERED UNDER THIS POLICY? NO YES If "Yes" please complete the following information: Regular COBRA If "Yes" Start Date: _____ End Date: _____

Insurance Company Name & Address	Covered Person	ID #	Group #	Coverage Type
				<input type="checkbox"/> MEDICAL
				<input type="checkbox"/> VISION
				<input type="checkbox"/> PHARMACY
				<input type="checkbox"/> DENTAL
				<input type="checkbox"/> OTHER

MEDICARE ELIGIBILITY (Complete this section if you, your spouse or dependents are covered by Medicare Part A and/or B). Are you or any of your dependents applying for coverage eligible for Medicare? Yes No If "Yes," whom: _____

(Note: If you are eligible for Medicare, you are not eligible to apply for this plan.)

APPLICANT MEDICAL HISTORY QUESTIONNAIRE

APPLICANT NAME	SOCIAL SECURITY NUMBER
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WARNING: 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.

COMPLETE THE FOLLOWING INFORMATION FOR ALL PERSONS (APPLICANTS) TO BE COVERED, INCLUDING YOURSELF. For purposes of the following medical questions, the term "medical or social practitioner" includes but is not limited to: a doctor, nurse, psychologist, social worker, chiropractor, podiatrist, osteopath, Christian Science practitioner, or a person affiliated with a self-help program such as Alcoholics Anonymous, a substance abuse program or a weight loss program.

Have YOU or any of your listed DEPENDENTS been diagnosed or treated in the past five years by a medical or social practitioner for any of the following conditions? All questions must be answered or the application will be returned.

(Please continue on next page.)

Failure to accurately and honestly disclose medical conditions may result in rescission of coverage or denial of a claim.

CONDITION	YES	NO	CONDITION	YES	NO
1. Abnormal Pap Smears	<input type="checkbox"/>	<input type="checkbox"/>	45. Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
2. AIDS, ARC or HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C		
3. Alcohol or Drug Dependency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chronic <input type="checkbox"/> Alcoholic		
4. Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other		
5. Anemia	<input type="checkbox"/>	<input type="checkbox"/>	46. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
6. Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	47. Hydrocephalus	<input type="checkbox"/>	<input type="checkbox"/>
7. Angina	<input type="checkbox"/>	<input type="checkbox"/>	48. Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>
8. Arthritis/Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	49. Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>
9. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	50. Ileostomy	<input type="checkbox"/>	<input type="checkbox"/>
10. Bronchitis (Chronic)	<input type="checkbox"/>	<input type="checkbox"/>	51. Kidney Disorders, including	<input type="checkbox"/>	<input type="checkbox"/>
11. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Polycystic Disease		
Treated 1-5 years ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Stones <input type="checkbox"/> Renal Failure		
Treated more than 5 years ago	<input type="checkbox"/>	<input type="checkbox"/>	52. Lou Gehrig's Disease	<input type="checkbox"/>	<input type="checkbox"/>
12. Cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>	53. Liver Disorders/Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>
13. Carotid Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	54. Meningitis	<input type="checkbox"/>	<input type="checkbox"/>
14. Carpel Tunnel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	55. Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>
15. Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	56. Migraines	<input type="checkbox"/>	<input type="checkbox"/>
16. Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	57. Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
17. Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	58. Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
18. Chronic Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	59. Myasthenia Gravis	<input type="checkbox"/>	<input type="checkbox"/>
19. Chronic Obstructive Pulmonary Disease (COPD)/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	60. Neck Pain, back pain, other back disorders	<input type="checkbox"/>	<input type="checkbox"/>
20. Colitis	<input type="checkbox"/>	<input type="checkbox"/>	61. Nervous or mental conditions including: Alzheimer's, Bipolar Disorder, Depression, Obsessive-Compulsive, Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>
21. Congenital Disorders	<input type="checkbox"/>	<input type="checkbox"/>	62. Organ Transplant/Failure	<input type="checkbox"/>	<input type="checkbox"/>
22. Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	63. Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
23. Coronary Artery Disease/Angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	64. Ovarian Cysts including Polycystic Ovarian Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
24. Coronary Insufficiency	<input type="checkbox"/>	<input type="checkbox"/>	65. Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>
25. Crohn's Disease/other stomach disorders	<input type="checkbox"/>	<input type="checkbox"/>	66. Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>
26. Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	67. Peptic Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
27. Cystitis	<input type="checkbox"/>	<input type="checkbox"/>	68. Peripheral Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
28. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	69. Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
29. Diverticulitis / Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>	70. Prostate Disorders	<input type="checkbox"/>	<input type="checkbox"/>
30. Downs Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	71. Quadriplegia	<input type="checkbox"/>	<input type="checkbox"/>
31. Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	72. Scleroderma	<input type="checkbox"/>	<input type="checkbox"/>
32. Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	73. Scoliosis or other Deformities	<input type="checkbox"/>	<input type="checkbox"/>
33. Fibrocystic Breast Disease	<input type="checkbox"/>	<input type="checkbox"/>	74. Spina Bifida Cystica	<input type="checkbox"/>	<input type="checkbox"/>
34. Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	75. Spinal Disorder/Disc Disorder Slipped, Herniated, Ruptured	<input type="checkbox"/>	<input type="checkbox"/>
35. Gallbladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	76. Stroke	<input type="checkbox"/>	<input type="checkbox"/>
36. Gastric Reflux	<input type="checkbox"/>	<input type="checkbox"/>	77. Systemic Lupus	<input type="checkbox"/>	<input type="checkbox"/>
37. Gout	<input type="checkbox"/>	<input type="checkbox"/>	78. Tendonitis	<input type="checkbox"/>	<input type="checkbox"/>
38. Grave's Disease	<input type="checkbox"/>	<input type="checkbox"/>	79. Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>
39. Gillian Barre' Disease			80. TMJ	<input type="checkbox"/>	<input type="checkbox"/>
40. Hernia <input type="checkbox"/> Hiatal <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	81. Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
41. Heart Disorder <input type="checkbox"/> Attack <input type="checkbox"/> Murmur <input type="checkbox"/> Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	82. Transcient Ischemic Attacks	<input type="checkbox"/>	<input type="checkbox"/>
42. Heart Bypass	<input type="checkbox"/>	<input type="checkbox"/>	83. Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
43. Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>			
44. Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>			

1. Name, Address and Phone Number of Personal Physician:
2. Explain below if any person listed on the application, in the past five years, had any signs or symptoms, seen a medical or social practitioner, had treatment recommended by a medical or social practitioner, including prescription medications, had been advised to reduce alcohol intake, had received treatment (medical or otherwise), or had been hospitalized for any other medical, surgical or health condition that is not stated in questions 1-83?
3. Has future surgery, diagnostic testing or medical treatment been recommended by a medical or social practitioner for you or any of your listed DEPENDENTS? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," explain:
4. In the last five years have any applicants had an abnormal physical exam, CT scan, MRI, laboratory tests or x-rays? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Are YOU or any of your listed DEPENDENTS currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," due date:
6. Have YOU or any of your listed DEPENDENTS taken prescribed medications within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" list medications and dosage on the chart below.
7. Has any insurance company, health plan, medical benefits carrier or welfare benefit plan refused, canceled or restricted health coverage for YOU or any of your listed DEPENDENTS within the last five years? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please explain:
8. Do YOU or any of your DEPENDENTS have a condition covered by Worker's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please list the condition and the Worker's Compensation Number:
9. During the past 12 months, has any applicant used any type of tobacco product? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," who, what kind of tobacco use, and how many pack(s)/day?

If any of the conditions are checked "YES" in the chart or questions, please explain below (use additional paper if necessary). Please indicate specific location of condition (example: left hand), details of injury or condition. Also include what prescription medications you and any dependent have used in the last 12 months.

Question # of Yes	Patient's Name	Conditions, Diagnosis & Type of Treatment	Medications & Dosages	Hospitalized or Surgery Performed (Yes/No)	Attending Physician & Phone Number	Date(s) of Treatment(s) & Medication Use	Degree of Recovery
Sample #63	Larry	Ear Infection	Amoxicillin 250 mg. 4x day	Tubes inserted 9/2002	Dr. John Doe 330-555-5555	8/2002 to 9/2002	Full Recovery

Other Health Coverage

If you or any of your dependents have had any other health coverage within the last 12 months, you may be eligible for a pre-existing credit. If so, please attach a copy of a HIPAA Certificate of Creditable Coverage to this application. (This can be obtained through your prior carrier.)

1. Have you had previous coverage from Summa Insurance Company? Yes No If "Yes", what type of coverage did you have? Group (through an employer) COBRA Conversion Open Enrollment Other Complete below Name of the prior carrier. (Use separate sheet if more than one prior carrier.)

Name of Prior Carrier: _____ Telephone Number: _____

Identification Number: _____ Covered Persons: _____

Effective Date: _____ Date of Termination: _____

BILLING INFORMATION

Method of Payment: VISA MasterCard Direct Debit from Savings/Checking Check

\$_____ Total Amount Enclosed or to be Charged ONE time ONLY Credit Card Draw

Please fill out information below:

For Credit Card or Debit Card automatic draw (Card must have either MasterCard or VISA logo to be processed):

Card Holder's Name

Account Number

Expiration Date

CVV NUMBER (last three digits of the number located on the signature strip on the card)

I (we) hereby authorize Summa Insurance Company and the financial institution issuing the Credit/Debit Card named below to initiate charges, and if necessary, credits to my account listed below. I (we) acknowledge that the origination of Credit/Debit Card transactions to my (our) account must comply with the provision of U.S. law.

Your account must show as paid in full in order to be eligible for this program. Payment will be drawn on the first business day of each month. ACH transactions returned for insufficient funds will be charged a \$25.00 NSF fee. This authority will remain in full force and effect until COMPANY has received written notification from me of its termination in such time and manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act upon it. **Send any termination or change request to:** Premium Billing, Summa Insurance Company, PO Box 3620, Akron, OH 44309-3620.

Print Policyholder's Name _____
Policyholder Number/ Division Number

Street Address _____
City, State, ZIP

Signature _____
Date

DIRECT DEPOSIT AUTHORIZATION FORM

Company Name: Summa Insurance Company ID No. 32-1726655

For Checking/Savings Automatic Draw:

Financial Institution Name

Branch Name

Address

City, State, ZIP

Billing Number

Account Number

I (we) hereby authorize Summa Insurance Company and the financial institution named below to initiate electronic debit entries, and if necessary, credit entries to my account listed below. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provision of U.S. law. **Please include a voided check to eliminate discrepancies in account information.**

Miscellaneous Information:

How did you hear about Individual Solutions?

- Insurance Agent
- Web site/Search Engine
- Radio

- Print Advertising
- Direct Mail
- Friend/Family Member

- Phone Book
- Time Warner Bill Insert
- Other _____

TERMS AND CONDITIONS

To be considered for enrollment in this Policy:

Applicant and dependents understand that they are responsible for reporting to Summa Insurance Company, within 31 days, any changes in their marital status, in the number of eligible dependents, or any change in health coverage or residence.

Applicant understands that no agent or Plan representative may permit or encourage an applicant to answer any questions inaccurately, untruthfully, or incompletely, and applicant represents that such did not occur. The selling agent has NO authority to promise me coverage or to modify Summa Insurance Company underwriting policy or terms of any coverage.

I understand that I am applying for Individual health coverage (under Summa Insurance Company Individual Solutions) which is not part of any employer-sponsored plan. I understand that I am responsible for 100% of the premiums.

Applicant and dependents authorize any physician, other healthcare professional, health plan, insurance company, medical benefits carrier, welfare benefit plan, hospital, pharmacy, pharmacy benefit manager or any other healthcare organization to give to Summa Insurance Company or its agent's information concerning the medical history, prescription history, services or treatment provided to anyone listed on this enrollment form. I further authorize Summa Insurance Company to disclose such information to vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, or to conduct related activities.

Applicant understands that he/she has an obligation to communicate to Summa Insurance Company in writing any medical conditions, which occur, to applicant or to any of applicant's dependents listed in this Enrollment form after the signature of the Enrollment form and before the effective date of the coverage, if approved. Upon making changes to your policyholder status with Summa Insurance Company, you and any affected dependents will be asked to submit a revised signed Enrollment form. Even if I pay money with this application that money is only a deposit against future premiums IF this application is accepted. Cashing my check does not mean my application is approved. If this application is declined, Summa Insurance Company shall not have any liability to me or anyone else listed on this application, except for the obligation to return the money submitted, minus any claims paid. If this application is not accepted, neither I nor anyone listed on it will be entitled to benefits from Summa Insurance Company.

I understand that pre-existing conditions are limited to 12 months after enrollment for conditions in existence within 6 months immediately prior to my enrollment for which medical advice, diagnosis, care or treatment was recommended or received. Pregnancy is considered a pre-existing condition.

Applicant and dependents understand and agree that no benefits shall take effect until application is approved for coverage. An identification card(s) will be issued, as soon as possible, to evidence coverage upon acceptance. Any applicant obligated for any part of a prepayment may cancel such agreement within 10 days after he/she has signed an agreement application to enroll. Cancellation occurs when written notice of cancellation is submitted to the Summa Insurance Company or its agents or other representatives. Cancellation within the 10 day period will render the policy void from the beginning. The prepayment will be returned in full and applicant will be responsible for any claims incurred during that time period. If you leave Summa Insurance Company's Individual policy for a Summa Insurance Company or SummaCare group policy and there is no lapse in coverage, the Individual application will cancel on the effective date of the Group plan. However, you must still notify us of this change so you will not be double billed.

Applicant acknowledges that he/she has received the Notice of Privacy Practices, which outlines how Summa Insurance Company uses and discloses his/her health information and his/her rights as a member. Do not cancel your present insurance coverage until you receive written notification from Summa Insurance Company that your new coverage is in force.

APPLICANT MUST SIGN AND DATE THE FOLLOWING CERTIFICATION AND AUTHORIZATION:

I certify that all information supplied on this form is true and complete to the best of my knowledge. I understand that all benefits for my eligible dependents and me will be provided in accordance with the policy. I am familiar with, have personally read and completed this application. I agree to abide by the terms and conditions governing this application and the delivery of health services covered under this policy, and agree to the provisions stated on this form, which I have read and understand. I understand that under the Summa Insurance Company Individual plan, I will be entitled to lesser benefits if I use an out-of-network hospital or physician than if I use a network hospital or physician. I ALSO UNDERSTAND THAT

MATERIAL OMISSIONS AND INTENTIONAL MISREPRESENTATIONS REGARDING INFORMATION PROVIDED ON THIS APPLICATION COULD CAUSE A COVERED SERVICE TO BE DENIED AND/OR COULD VOID ANY COVERAGE ISSUED. I FURTHER UNDERSTAND THAT I WILL BE RESPONSIBLE TO REIMBURSE SUMMA INSURANCE COMPANY FOR ALL PAID CLAIMS IF I OMIT (WHETHER INTENTIONAL OR NOT), INFORMATION ON THIS APPLICATION OR FAIL TO PROVIDE INFORMATION REGARDING MY MEDICAL HISTORY AND/OR MEDICAL CONDITIONS, AS REQUESTED BY SUMMA INSURANCE COMPANY.

If applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application.

APPLICANT (OR GUARDIAN)

SIGNATURE _____ **DATE** _____

SPOUSE SIGNATURE _____ **DATE** _____

IMPORTANT!

If using a Broker to enroll, list Broker name here: _____

If Broker is writing through a General Agent, please list Agency here: _____

Agency Phone Number _____

AGENT SIGNATURE _____

I certify that I am not aware of any undisclosed information by the applicant relating to the health, and habits of any person listed on this application which might have a bearing on the risk. I verify this application was completed by the applicant. THIS PLAN IS UNDERWRITTEN BY SUMMA INSURANCE COMPANY AND ADMINISTERED BY SUMMACARE.

I hereby authorize any health care provider or medically related facility, pharmacy, or pharmacy related facility, the Medical information Bureau, any pharmaceutical information data source, consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested to Summa Insurance Company, its contracted or legal representatives or any medical or pharmaceutical records retrieval service Summa Insurance Company may engage, including, but not limited to EMSI.

This authorization includes any and all information you may have about me, including, but not limited to information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, lab data, and EKGs. This information may also be disclosed to any medical records company engaged by Summa Insurance Company, including, but not limited to EMSI and its agents. Although federal regulations required that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Summa Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy or facsimile of this authorization will be as valid as the original.

I understand that this authorization is required in order to enable Summa Insurance Company to make eligibility, enrollment, benefit determinations, and underwriting and risk rating determinations relating to me and/or my minor children. If I refuse to sign or revoke this authorization, Summa Insurance Company may refuse to consider my application for enrollment.

I understand that I may revoke this authorization at any time by notifying Summa Insurance Company in writing of my desire to revoke. Such revocation must be sent by United States Postal Service Certified Mail to the following address: Summa Insurance Company, Attn: Compliance, 10 North Main Street, Akron, Ohio 44308. Such revocation will not be valid if Summa Insurance Company has taken action in reliance on the authorization.

Unless an earlier date is required by law, this authorization expires on the earliest of the following events: denial of my application, declination for enrollment, or if insured, when I am no longer an insured of Summa Insurance Company.

Signature(s) APPLICANT* _____
 SPOUSE _____

 DEPENDENT _____
 DEPENDENT _____
 DEPENDENT _____
 DEPENDENT _____

* If you are requesting coverage as a representative for any minor individual on this application and are not the parent or legal guardian, or if you are requesting coverage as a representative of the applicant you must attach documentary evidence of your authority to act as the individual's representative for this authorization to be valid.

