Critical Illness Cash - Sales Kit

Sale Kit Inlcudes the following:

-Application

-Conditional Receipt

-State Required Sales Forms

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GCA08IFHH

Application for Critical Illness Insurance
Kanawha Insurance Company

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PLEASE INDICATE: ○ NEW COVERAGE ○ CHANGE TO EXISTING COVERAGE ○ CONTINUATION OF COVERAGE

Person(s) Proposed for Coverage

Primary Insured (Please Print)

First Name | MI | Last Name | Suffix

Birthdate (MM/DD/YYYY) / / | State of Birth | Height (Ft-In) - | Weight | Social Security Number - -

Address (Street or R.R.)

Gender ○ Male ○ Female

City | State | ZIP Code | Home Telephone ( ) -

Have you used any form of tobacco in the past 12 months?..... ○ Yes ○ No

Spouse

Spouse Name (First Name, MI, Last Name) (If proposed for coverage) | Suffix | State of Birth

Birthdate (MM/DD/YYYY) / / | Height (Ft-In) - | Weight | Social Security Number - -

Gender ○ Male ○ Female

Have you used any form of tobacco in the past 12 months?..... ○ Yes ○ No

Child One

Child Name (First Name, MI, Last Name) (If proposed for coverage) | Suffix | State of Birth

Birthdate (MM/DD/YYYY) / / | Height (Ft-In) - | Weight | Social Security Number - -

Gender ○ Male ○ Female

Child Two

Child Name (First Name, MI, Last Name) (If proposed for coverage) | Suffix | State of Birth

Birthdate (MM/DD/YYYY) / / | Height (Ft-In) - | Weight | Social Security Number - -

Gender ○ Male ○ Female

Child Three

Child Name (First Name, MI, Last Name) (If proposed for coverage) | Suffix | State of Birth

Birthdate (MM/DD/YYYY) / / | Height (Ft-In) - | Weight | Social Security Number - -

Gender ○ Male ○ Female

[210 South White Street, Lancaster SC 29720
Mail: Post Office Box 7777, Lancaster SC 29721-7777 1-877-207-0158]
Kanawha Insurance Company is a member of the Humana family of companies.

BENEFIT SECTION

Plan Type ○ Individual (Adult) ○ Couple [(Individual and spouse/partner)]
○ Family (2 parents and all children) ○ Single Parent (Parent and all children)

Base Plan (Select Only One) ○ Vascular, Cancer and Other Illnesses ○ Vascular and Other Illnesses ○ Cancer Only

Primary Insured/Spouse Benefit Amount: $,

Child(ren) Benefit Amount: $,

Total Modal Premium: $.

Optional Benefit: Return of Premium ○ Yes ○ No

Payment Method ○ Bank Draft ○ Credit Card ○ Direct Bill/Check (Annual Billing Only)
[(Complete Bank Draft or Credit Card Authorization. Annual fee of $12.00 applies to credit card billing.)]

Payment Mode ○ Monthly ○ Semi-annual ○ Annual

Beneficiary:

○ 100% to my Spouse, as recorded on Page 1 of this Application

○ Other (List name, relationship and percentage share) _____

_____

APPLICANT'S REPRESENTATION AND AGREEMENT

	Primary Insured	Spouse	Child 1	Child 2	Child 3
	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
1. In the last 12 months, has any Person Proposed for Coverage:					
a. Been unable to perform their normal duties at work, home or school on a full-time basis due to an illness or disability?	○ ○	○ ○	○ ○	○ ○	○ ○
b. Missed more than 5 consecutive days of work or school due to an illness or injury?	○ ○	○ ○	○ ○	○ ○	○ ○
2. Has any Person Proposed for Coverage ever been treated for or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or tested positive for the antigens or antibodies to an AIDS (HIV) virus?	○ ○	○ ○	○ ○	○ ○	○ ○
3. In the 6 months prior to the Application date, has any Person Proposed for Coverage been hospitalized as an inpatient or treated on an outpatient basis, except for minor injuries or normal pregnancy?	○ ○	○ ○	○ ○	○ ○	○ ○
4. Has any Person Proposed for Coverage ever been diagnosed with or treated for drug abuse or alcohol abuse, disease of the liver, kidney or digestive system, disease or disorder of the lung, diseases of the nervous system, including Parkinson's, multiple sclerosis, cerebral palsy, hemiplegia, paraplegia, quadriplegia, or any disease or disorder which has led or may lead to a permanent or progressive loss of vision or speech?	○ ○	○ ○	○ ○	○ ○	○ ○
5. Has any Person Proposed for Coverage ever been diagnosed with or treated for heart disease, including angina, heart attack, congestive heart failure, heart bypass, cerebrovascular disease including Transient Ischemic Attack (TIA), stroke (blockages or hemorrhage), diabetes, or blood pressure readings above the normal range which have not been controlled with medication?	○ ○	○ ○	○ ○	○ ○	○ ○
6. Has any Person Proposed for Coverage ever been diagnosed with or treated for Cancer, including melanoma, leukemia, lymphoma, malignant tumors, or skin cancers?	○ ○	○ ○	○ ○	○ ○	○ ○
7. To the best of your knowledge and belief, have any two of your natural parents or natural siblings (sisters or brothers) been diagnosed with the same disease before age 60 based on the following list:					
a. Vascular: heart attack, heart disease or stroke?	○ ○	○ ○	○ ○	○ ○	○ ○
b. Cancer: cancer?	○ ○	○ ○	○ ○	○ ○	○ ○
c. Other: kidney disease, diabetes?	○ ○	○ ○	○ ○	○ ○	○ ○

8. Does any Person Proposed for Coverage have any other Critical Illness coverage in force or an Application for similar insurance pending with this or any other company?..... ○ Yes ○ No
If "YES", please provide details with specific benefit amounts below.

9. Will the policy applied for replace any coverage currently in force?..... ○ Yes ○ No
If "YES", please complete the following.

Company	Person Covered	Policy Number

Payor Information

Payor Information (First, MI, Last Name) (If different than the Proposed Insured) Suffix

Social Security Number

- -

Address (Street or R.R.)

City State ZIP Code

Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud.

I/We have read or had read to me all the questions on this Application and I/We represent the answers and any information provided are correct and complete to the best of my knowledge and belief. I/We also realize that any false statements or misrepresentation may result in loss of coverage under the policy subject to the Time Limit on Certain Defenses or Incontestability provisions of the policy. I/We understand and agree that the policy will not take effect unless it is issued by Kanawha Insurance Company, the total modal premium must accompany the Application, and any check, bank draft or credit card payment is honored on first presentation. No agent or producer has the authority to waive any of the conditions or questions in this Application. I/We acknowledge, if required in my state, that I/We have been furnished:

☐ Outline of Coverage ☐ Medicare Buyer's Guide (If age 65 or over) ☐ MIB Disclosure Notice

AUTHORIZATION

By this form (or photocopy of it), which is valid for 30 months from the date shown below, I/We authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, pharmacy, pharmacy benefit manager or other pharmacy related services organization, insurance company, the Medical Information Bureau, or other person, organization, or institution, that has any records or knowledge of me, my spouse or my child(ren) for whom insurance Application is made, or my health, my spouse's or my child(ren)'s health, to give to Kanawha Insurance Company, or its reinsurers, any such information and to testify as to such information, all to the extent permitted by law. I understand that such information will be used by Kanawha Insurance Company for the purpose of evaluating my Application for insurance.

I/We understand that I/We have the right to revoke this Authorization in writing, at any time, by providing written request for revocation to: Kanawha Insurance Company at 210 South White Street, Lancaster, SC 29720, Attention: Underwriting Department. I/We understand that a revocation is not effective to the extent that Kanawha Insurance Company has relied upon information disclosed prior to the revocation. I/We understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

Signed At _____ State

/ / Date (MM/DD/YYYY)

Signature of Applicant/Owner/Primary Insured

Signature of Spouse (If Proposed for Coverage)

AUTHORIZATION FOR AUTOMATIC PAYMENT BY BANK DRAFT

Attach Voided Check

Name of Depositor (First, MI, Last Name) (Attach Voided Check) Suffix

Route and Transit Number

Account Number

Bank Name and Address

Debit on the ____ day of the month (1-28 only; 29, 30, 31 not available). **If no election is made, debits will be made on the day of Policy.**

As a convenience to me, I request and authorize **KANAWHA INSURANCE COMPANY** to make deductions automatically every payment period for payments of premiums from my: ○ savings account ○ checking account

1. Each debit shall constitute proper notice of premium due and will be made on the day selected above or, if no day is selected, the day of Policy.
2. This Authorization shall not become effective unless and until the coverage is issued.
3. This Authorization shall not be construed as modifying any provisions of the coverage.
4. Kanawha shall not incur any liability if a draft is returned unpaid by the bank. Drafts which do not clear within the time stipulated in the Policy for payment of premium shall constitute nonpayment of premiums and coverage shall lapse subject to nonforfeiture provisions.
5. This Authorization may be discontinued by Kanawha or by the Undersigned at any time within FIVE (5) business days prior to the debit date. Upon termination of this Authorization, the premiums on the Policy covered will be payable annually.
6. Kanawha will notify me TEN (10) days prior to any changes in payment amounts.

Signature of Depositor _____ Date (MM/DD/YYYY) ____ / ____ / ____

Card Holder Information

CREDIT CARD INFORMATION

Credit Card Number

Expiration Date (MM/YY) ____ / ____

Card Type ○ Visa ○ Mastercard

3 or 4-digit security code found on the back of most cards:

Name as it appears on the credit card (If different than Proposed Insured)

Card Holder (First Name, MI, Last Name) Suffix

All charges will be made on the day of Policy.

As a convenience to me, I request and authorize **KANAWHA INSURANCE COMPANY** to charge my credit card every payment period for payment of premiums.

1. Each charge shall constitute proper notice of premium due.
2. This Authorization shall not become effective unless and until the Policy is issued.
3. This Authorization shall not be construed as modifying any provisions of the Policy.
4. Kanawha shall not incur any liability if the credit card company does not honor the charge and the Policy shall lapse subject to nonforfeiture provisions.
5. This Authorization may be discontinued by Kanawha or by the undersigned at any time within FIVE (5) business days prior to the payment date. Upon termination of this Authorization, premiums for the Policy will be payable annually.
6. Kanawha will notify me TEN (10) days prior to any changes in payment amounts.

Signature of Card Holder _____ Date (MM/DD/YYYY) ____ / ____ / ____

FOR INSURANCE PRODUCER'S USE ONLY

I certify any information recorded by me on this Application is true and accurate to the best of my knowledge and belief.

Will this insurance replace any existing insurance?..... ○ Yes ○ No

Date (MM/DD/YYYY)

Signature of Licensed Insurance Producer _____ / /

Printed Name of Licensed Insurance Producer _____

Insurance Producer Number	% Credit	Insurance Producer Number	% Credit	Insurance Producer Number	% Credit

DETACH AND GIVE THIS PAGE TO PROPOSED INSURED

MIB Disclosure Notice - Detach and Give to Proposed Insured

Information regarding your insurability will be kept confidential. Kanawha Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, email address www.mib.com and telephone number (781) 751-6000. Kanawha Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

NOTICE TO PROPOSED INSURED

Thank you for giving Kanawha the opportunity to consider your insurance needs. As part of our normal procedure for processing Applications, we may order an investigative consumer report. This includes your prescription drug history and information as to your character, general reputation, personal characteristics, and mode of living. The information obtained in such investigative consumer report will not be used to make a determination of your sexual preference. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation. You may request to be interviewed in connection with the preparation of this investigative consumer report and upon request you are entitled to receive a copy of the investigative consumer report. If you question the accuracy of information in the investigative consumer report, you may contact the Consumer Reporting Agency and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. We may telephone you to confirm information given in your Application or to obtain additional information needed to process your Application. All information asked for in your Application, or obtained from other sources, such as your physician, or hospitals where you have been treated, is for the sole purpose of determining your acceptability for the insurance coverage for which you have applied. All information obtained will be kept confidential. Upon your written request, we will furnish you or your physician with the nature or source of the information.

KANAWHA INSURANCE COMPANY

Mail: Post Office Box 610, Lancaster, South Carolina 29721-0610
Delivery: 301 South Main Street, Lancaster, South Carolina 29720
1-800-378-1505 (toll free) or 803-283-5300

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, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance, and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- Other approved items and services

BEFORE YOU BUY THIS INSURANCE

✓ Check the coverage in all health 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 Kanawha Insurance Company.

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

_____ _____

Date Signature of Proposed Insured

KANAWHA INSURANCE COMPANY

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CONDITIONAL RECEIPT

A Conditional Receipt is to be given to an applicant upon receipt of the applicant's check as a deposit for the modal premium(s) for the Policy(ies) applied for herein.

Make checks payable to Kanawha Insurance Company. Do not make payable to Insurance Producer or leave payee blank.

Received from _____ the _____ day of _____, _____
Name Month Year

the sum of $_____ being the payment of _____ month(s) premium for the following policies

_____

_____

_____

_____.

The insurance applied for shall not take effect until:

- the date of Policy,
- payment of the modal premium, and
- the Proposed Insured(s) has been approved for coverage as applied.

In the event the application is declined, any payment made by the applicant will be returned.

No coverage is provided under this Conditional Receipt unless the conditions on this receipt are fulfilled.

No coverage is provided for any claims that begin prior to the approval date.

No coverage is provided under this Conditional Receipt if the Proposed insured misrepresented a material fact or facts in the Application for insurance/ reinstatement Application.

No insurance producer can waive or alter any of the conditions or requirements stated on this conditional receipt.

_____ _____
Signature of Insurance Producer/Policy Administrator Telephone Number of Insurance Producer

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