# Hospital Cash - Sales Kit

Sale Kit Inlcudes the following:

-Application

-Conditional Receipt

-State Required Sales Forms

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# Application for Hospital Indemnity
# Kanawha Insurance Company

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PLEASE INDICATE: ○ NEW COVERAGE ○ CHANGE TO EXISTING COVERAGE ○ CONVERSION

Person(s) Proposed for Coverage

## Primary Insured (Please Print)

First Name | MI | Last Name | Suffix

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

Address (Street or R.R.)

City | State | ZIP Code

Home Telephone

( ) -

## Spouse

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

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

## Child One

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

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

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

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]

## BENEFIT SECTION

**Plan Type** ○ Individual (adult or child) ○ Family (2 parents and all children) ○ Single Parent (parent and all children)

**Base Benefit** ○ $250 ○ $500 ○ $1,000 ○ $1,500 ○ $2,000

**Optional Benefit: Hospital Confinement Daily Benefit Rider / Intensive Care Unit (ICU) Daily Benefit**

○ $50/day ($200/day if ICU) ○ $100/day ($400/day if ICU) ○ $200/day ($800/day if ICU)

**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 **Total Modal Premium** $ ___ . ___

## 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. Has anyone proposed for coverage ever been diagnosed or treated by a member of the medical profession as having: | | | | | |
| a. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive to the antibodies for Human Immunodeficiency Virus (HIV)..... | ○ ○ | ○ ○ | ○ ○ | ○ ○ | ○ ○ |
| b. Alzheimer's Disease..... | ○ ○ | ○ ○ | ○ ○ | ○ ○ | ○ ○ |
| c. Senile dementia..... | ○ ○ | ○ ○ | ○ ○ | ○ ○ | ○ ○ |
| d. Uncorrected congenital heart defect (excluding mitral valve prolapse)..... | ○ ○ | ○ ○ | ○ ○ | ○ ○ | ○ ○ |
| e. Kidney disease (not including kidney stones)..... | ○ ○ | ○ ○ | ○ ○ | ○ ○ | ○ ○ |
| f. Systemic lupus..... | ○ ○ | ○ ○ | ○ ○ | ○ ○ | ○ ○ |
| g. Insulin-dependent diabetes..... | ○ ○ | ○ ○ | ○ ○ | ○ ○ | ○ ○ |
| h. Liver disease or disorder (excluding Hepatitis A)..... | ○ ○ | ○ ○ | ○ ○ | ○ ○ | ○ ○ |
| 2. a. Is any person proposed for coverage currently confined in a hospital, nursing home, or any medical facility?..... | ○ ○ | ○ ○ | ○ ○ | ○ ○ | ○ ○ |
| b. Has a member of the medical profession recommended hospitalization, surgery, or nursing home confinement that has not yet occurred?..... | ○ ○ | ○ ○ | ○ ○ | ○ ○ | ○ ○ |
| 3. Within the last 5 years has any person proposed for coverage been diagnosed or treated by a member of the medical profession for internal cancer (except basal cell cancer)?..... | ○ ○ | ○ ○ | ○ ○ | ○ ○ | ○ ○ |
| 4. Within the past 2 years has any person proposed for coverage been hospitalized or seen in an emergency room by a member of the medical profession for: | | | | | |
| a. Angioplasty, stent placement, heart surgery..... | ○ ○ | ○ ○ | ○ ○ | ○ ○ | ○ ○ |
| b. Angina (heart related chest pain), heart attack, hypertension, congestive heart failure, peripheral vascular disease (circulatory problems)..... | ○ ○ | ○ ○ | ○ ○ | ○ ○ | ○ ○ |
| c. Emphysema, chronic lung disease, asthma ..... | ○ ○ | ○ ○ | ○ ○ | ○ ○ | ○ ○ |
| d. Cerebral vascular accident (CVA, stroke), cerebral vascular insufficiency, transient ischemic attack (TIA, ministroke)..... | ○ ○ | ○ ○ | ○ ○ | ○ ○ | ○ ○ |
| e. Type II diabetes..... | ○ ○ | ○ ○ | ○ ○ | ○ ○ | ○ ○ |
| f. Parkinson's Disease..... | ○ ○ | ○ ○ | ○ ○ | ○ ○ | ○ ○ |
| g. Crohn's Disease, ulcerative colitis..... | ○ ○ | ○ ○ | ○ ○ | ○ ○ | ○ ○ |
| h. Sickle cell anemia..... | ○ ○ | ○ ○ | ○ ○ | ○ ○ | ○ ○ |
| i. Transplants..... | ○ ○ | ○ ○ | ○ ○ | ○ ○ | ○ ○ |

5. Does any person proposed for coverage have any other Hospital Indemnity 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.

6. 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 have read or had read to me all the questions on this Application and I represent the answers and any information provided are correct and complete to the best of my knowledge and belief. I 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 understand and agree that the policy will not take effect unless it is issued by Kanawha Insurance Company, the total modal premium must accompany 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 acknowledge, if required in my state, that I have been furnished:

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

Signed At _____
City

State

_____
Signature of Primary Insured/Owner
(Parent or Guardian if Child only coverage)

/ / 
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 |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

## 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) ____ / ____ / ____

## CREDIT CARD INFORMATION

**Card Holder 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:

Signature of Card Holder_____ Date (MM/DD/YYYY) ____ / ____ / ____

**Name as it appears on the credit card statement** (If different from 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) ____ / ____ / ____

# 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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Kanawha Insurance Company is a member of the Humana family of companies.