## Hospital Cash - Sales Kit

Sale Kit Inlcudes the following:

- -Application
- -Conditional Receipt
- -State Required Sales Forms



## **Application for Hospital Indemnity**

1664

## **Kanawha Insurance Company**



3747582062

		•						
PLEA:	SE INDICATE: O NEW COVERAGE O CHANGE TO EXISTING COVERAGE O CONVERSI	ON						
Person(s) Proposed for Coverage								
	First Name MI Last Name	Suffix						
Primary Insured (Please Print)								
e F	Birthdate (MM/DD/YYYY) Height (Ft-In) Weight Social Security Number	Gender						
eas		O Male O Female						
<u>a</u>	Address (Street or R.R.)							
Jed Jed								
Sur	City State ZIP Code							
\   <u>\</u>								
Tar,	Home Telephone							
rin'								
	Spouse Name (First Name, MI, Last Name) (If proposed for coverage)	Suffix						
Se								
Spouse	Birthdate (MM/DD/YYYY) Height (Ft-In) Weight Social Security Number	Gender						
S	/ / /	O Male O Female						
e	Child Name (First Name, MI, Last Name) (If proposed for coverage)	Suffix						
Child One								
) ild	Birthdate (MM/DD/YYYY) Height (Ft-In) Weight Social Security Number	Gender						
ਠ	, , , , , , , , , , , , , , , , , , , ,	O Male O Female						
$\sqsubseteq$		0.55						
9	Child Name (First Name, MI, Last Name) (If proposed for coverage)	Suffix						
Child Two								
) ji	Birthdate (MM/DD/YYYY) Height (Ft-In) Weight Social Security Number	Gender						
ਹਿੱ		○ Male ○ Female						
(e)	Child Name (First Name, MI, Last Name) (If proposed for coverage)	Suffix						
hre								
Child Three	Birthdate (MM/DD/YYYY) Height (Ft-In) Weight Social Security Number	Gender						
<b> </b>		O Male O Female						
		o Maic o i citiale j						

_	BENEFIT SECTION										
	Plan Type O 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										
		lm:4 /		\ D.	-:I- <i>-</i>	Da.	<b>£</b> :				
	Optional Benefit: Hospital Confinement Daily Benefit Rider/Intensive Care L			) Da	ally	Ber	теті	τ			
(	\$50/day (\$200/day if ICU) \$100/day (\$400/day if ICU) \$200/day (\$800/day	y if IC	CU)								
ı	Payment Method O Bank Draft O Credit Card O Direct Bill/Check (Annual Billing	g Only	)								
	(Complete Bank Draft or Credit Card Authorization. Annual fee of \$	312.00	) ap	plies	s to	crec	dit c	ard	billi	ng.)	
				-	_	1 -	-	-			
l	Payment Mode ○ Monthly ○ Semi-annual ○ Annual Total Modal Premi	ium	\$			l.					
						-		_			,
	APPLICANT'S REPRESENTATION AND AGREEMENT									$\overline{}$	<u> </u>
		Drin	nary						$\neg$		
1.	Has anyone proposed for coverage ever been diagnosed or treated by a member of the medical profession as having:	Insu	ıred	Spo	ouse	Chil	ld 1	Chile	d 2	Child	13
	a. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC),	Yes	/No	Yes	s/No	Yes	/No	Yes/	/No	Yes/	No
	or tested positive to the antibodies for Human Immunodeficiency Virus (HIV)		0		0			0	$\circ$	0	$\bigcirc$
	b. Alzheimer's Disease		Ö	0	O	0		O	0	Ö	
	c. Senile dementia		Ö			0	O	Ö	O	Ö	
	d. Uncorrected congenital heart defect (excluding mitral valve prolapse)	0	O	O	O	O	O	O	O	Ō	Ō
	e. Kidney disease (not including kidney stones)	0	0	0	0	0	0	0	0	0	0
	f. Systemic lupus	0	0	0	0	0	0	0	0	0	0
	g. Insulin-dependent diabetes	0	0	0	0	0	0	0	0	0	0
2	h. Liver disease or disorder (excluding Hepatitis A)	0	0	0	0	0	0	0	0	0	0
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,	0	0	O	0	0	0	0	O	O	O
	or nursing home confinement that has not yet occurred?										
3.	Within the last 5 years has any person proposed for coverage been diagnosed or	0	0	0	0	0	0	0	0	O	U
	treated by a member of the medical profession for internal cancer (except basal cell										
	cancer)?		0	0	0	0		0	0	0	0
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	0	0	0	0	0	0	0	0	0	0
	b. Angina (heart related chest pain), heart attack, hypertension, congestive heart										
	failure, peripheral vascular disease (circulatory problems)		0		0	0		0		0	
	d. Cerebral vascular accident (CVA, stroke), cerebral vascular insufficiency,		0		0	0		0	O	0	O
	transient ischemic attack (TIA, ministroke)										
	e. Type II diabetes		0		0	0	0	0	00	0	
	f. Parkinson's Disease		O		O	1	0		0		0
	g. Crohn's Disease, ulcerative colitis		Ö		Ö		Ö			ŏ	
	h. Sickle cell anemia	1	Ö		Ö	0		Ö		Ö	
	i. Transplants			0			0	0		0	
`		<u> </u>				1				_	
5.	Does any person proposed for coverage have any other Hospital Indemnity coverage										
	for similar insurance pending with this or any other company?						(	) Ye	S:	0	No
	If "YES", please provide details with specific benefit amounts below.										
							_				
ó.	Will the policy applied for replace any coverage currently in force?							) Ye	?S	0	No
	If "YES", please complete the following.										
	Company Person Covered Policy Number										

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	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 prosecutic 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 provide 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 for 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:  Guttine of Coverage Medicare Buyer's Guide (If age 65 or over)  Signed At City State  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?								
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			+ +						
	1664 Page 3 0540582060								

	AUTHORIZATION FOR AUTOMATIC PAYMENT BY BANK DRAFT	
(왕	Name of Depositor (First, MI, Last Name) (Attach Voided Check)	Suffix
Attach Voided Check		
) p		
ide		
Vc	Route and Transit Number Account Number	
ıch	Bank Name and Address	
\tta		
	ebit on the day of the month (1-28 only; 29, 30, 31 not available). If no election is made, or	debits will be
	hade on the day of Policy.	one automatically
	s a convenience to me, I request and authorize <b>KANAWHA INSURANCE COMPANY</b> to make deduction very payment period for payments of premiums from my: osavings account ochecking account	ins automatically
1.	Each debit shall constitute proper notice of premium due and will be made on the day selected above	or, if no day is
2.	selected, the day of Policy. This Authorization shall not become effective unless and until the coverage is issued.	
	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 stipulated in the Policy for payment of premium shall constitute nonpayment of premiums and coverage	
_	subject to nonforfeiture provisions.	
5.	This Authorization may be discontinued by Kanawha or by the Undersigned at any time within FIVE (5 prior to the debit date. Upon termination of this Authorization, the premiums on the Policy covered w	
	annually.	
6.	Kanawha will notify me TEN (10) days prior to any changes in payment amounts.	
Siç	gnature of Depositor Date (MM/DD/YYYY) // //	
	CREDIT CARD INFORMATION	
ormation	Credit Card Number Expiration Date (MM/YY)  Car	rd Type
nat	Ulling Visa	<ul><li>Mastercard</li></ul>
	3 or 4-digit security code found on the back of most cards:	
Card Holder Inf		
ldel	Signature of Card Holder Date (MM/DD/YYYY)	
위	Name as it appears on the credit card statement (If different from Proposed Insured).	0.55
ard	Card Holder (First Name, MI, Last Name)	Suffix
ပိ		
۸۵	All charges will be made on the day of Policy.	dit cond over
	a convenience to me, I request and authorize <b>KANAWHA INSURANCE COMPANY</b> to charge my crec yment period for payment of premiums.	iit card every
	Each charge shall constitute proper notice of premium due.	
2. 3.	This Authorization shall not become effective unless and until the Policy is issued.  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 Police	cy shall lapse
5.	subject to nonforfeiture provisions.  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 Poli	су
	will be payable annually.  Kanawha will notify me TEN (10) days prior to any changes in payment amounts.	
6.	Kanawha will notify me TEN (10) days prior to any changes in payment amounts.	
Sig	nature of Card Holder Date (MM/DD/YYYY)	

### KANAWHA INSURANCE COMPANY

[210 S. WHITE STREET] [LANCASTER, SC 29720] [PO BOX 610] [LANCASTER, SC 29721-0610]

TELEPHONE: [877-207-0158]

## OUTLINE OF COVERAGE FOR HOSPITAL INDEMNITY POLICY FORM 90840 AR

#### A LIMITED BENEFITS POLICY

**PLEASE READ YOUR POLICY CAREFULLY**. This Outline of Coverage provides a very brief description of some of the important features of Your Policy. This is not the insurance contract. Only the actual Policy terms will control. The Policy itself states the rights and duties of both You and Kanawha Insurance Company ("Kanawha"). The Policy also states the benefits and requirements. It is therefore important that **YOU READ YOUR POLICY CAREFULLY!** Please contact Us if You have questions.

**LIMITED BENEFITS COVERAGE**. Policies of this type are designed to provide covered persons with limited or supplemental coverage. The Benefits Summary section below outlines the coverage provided by the Policy. Benefits described in the Benefits Summary may be limited by the Limitations and Exclusions sections, and other terms in Your Policy.

**NO RECOVERY FOR PRE-EXISTING CONDITIONS**. Except for congenital anomalies of a covered Dependent Child, no benefits will be provided during the first 12 months of the Policy and any attached Rider for any Pre-existing Condition, as defined in the Policy.

#### **BENEFITS SUMMARY**

**Hospital Confinement Lump Sum Benefit**. If a Covered Person is confined as an inpatient in a Hospital for the treatment of an Injury or Sickness, Kanawha will pay the Hospital Confinement Lump Sum Benefit Amount shown on the Policy Schedule. This benefit is subject to a maximum of one Hospital Confinement for each Covered Person each Calendar Year. Other maximums may apply as well.

	, ,,,	
Hospital Confinement Lump Sum Benefit Amount:	[\$	]
Emergency Room Treatment Lump Sum Benefit. If a Covered P Room Care in a Hospital emergency room due to an Injury or Sickn Room Treatment Lump Sum Benefit Amount shown on the Policy S maximum of two Hospital emergency room visits for each Covered maximums may apply as well.	ess, Kanawha will p schedule. This bene	ay the Emergency fit is subject to a
Emergency Room Treatment Lump Sum Benefit Amount:	[\$	]
Outpatient Surgery Lump Sum Benefit. If a Covered Person required Procedure due to an Injury or Sickness, Kanawha will pay to Benefit Amount shown on the Policy Schedule. This benefit is subjective Surgical Procedures for each Covered Person each Calendar Year.	the Outpatient Surgect to a maximum of	ery Lump Sum f two Outpatient
Outpatient Surgery Lump Sum Benefit Amount:	[\$	]

BENEFITS ARE PAYABLE SUBJECT TO ALL OF THE TERMS OF THE POLICY.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY

**GUARANTEED RENEWABLE**. You can keep Your Policy until the Policy Anniversary date following the Primary Insured's 70<sup>th</sup> birthday. You must pay each Premium due before the end of the Grace Period. Your Premium can be changed if Kanawha changes the Premium on all policies in Your Premium class. Kanawha will give 60 days written notice before such Premium change starts. If You move, Your Premium may also change.

**PREMIUM**. Your first Premium is [\$XXX.XX]. Your renewal Premium is stated below. Your Premium is subject to change as outlined above and as stated in Your Policy.

Modal Premium:	[\$	
Payment Mode:	[	]
If You have Rider coverage under Your Policy, the ab	ove stated Premium includes Rider	coverage.
<b>GRACE PERIOD</b> . A Grace Period of 31 days is proving the first Premium. Coverage will remain in force during the		ue, except for the
OPTIONAL HOSPITAL CONFINEMENT DAILY BEN	IEFIT RIDER (FORM 90841 AR)	
Rider benefits are provided as outlined below for Coverage. You have Rider coverage if You applied for and the Rider was issued attached to Your Policy. If the received it, then the Rider coverage is not available to summary of Rider benefits. The terms contained in the	or it, if such coverage is shown on the this Rider was not attached to Your Folicy o Covered Persons under Your Policy	e Policy Schedule Policy when You y. This is only a
Hospital Confinement Daily Benefit. For each Full Hospital, Kanawha will pay the Hospital Confinement Kanawha will pay this daily amount up to a total of 30	Daily Benefit Amount shown on the	Policy Schedule.
Hospital Confinement Daily Benefit Amount:	[\$]	
Intensive Care Unit Daily Benefit. For each Full Da or she is a patient in the Hospital's Intensive Care Uni (ICU) Daily Benefit Amount shown on the Policy Sche Hospital Confinement.	it (ICU), Kanawha will pay the Intens	ive Care Unit
Intensive Care Unit (ICU) Daily Benefit Amount:	[\$]	
For each Full Day that a Covered Person is in the ICL Confinement Daily Benefit and the Intensive Care Uni Day.		
LIMITATIONS		
Waiting Period(s)		

## Six Months

No benefits are provided or paid under the Policy or Rider for care or treatment occurring during the first six (6) months from the Date of Policy/Rider for the following (unless on an emergency basis):

- cancer;
- hernia(s); and
- adenoids, tonsils or appendix.

#### **Ten Months**

No benefits are provided or paid under the Policy or Rider for care or treatment occurring during the first ten (10) months from the Date of Policy/Rider for the following:

- pregnancy; and
- childbirth.

#### **Twelve Months**

No benefits are provided or paid under the Policy or Rider for care or treatment of any Covered Person donating an organ occurring during the first twelve (12) months from the Date of Policy/Rider.

#### **EXCLUSIONS**

No benefits are provided or paid under the Policy or Rider for any loss, expense, care or treatment due or related to:

- intentionally self-inflicted Injury;
- suicide or any attempted suicide, whether sane or insane;
- mental or emotional disorders without demonstrable organic disease;
- Injury or Sickness incurred as a result of engaging in an illegal occupation;
- voluntary ingestion, injection, inhalation or use of any drug, narcotic or sedative, unless prescribed by and taken in accordance with the directions of the prescribing Physician;
- voluntary ingestion, injection, inhalation, taking, absorbing or use of any poison, poisonous gas, fumes or any other substance that results in Injury or Sickness;
- being intoxicated as intoxication is defined by the laws of the state in which the incident occurred;
- alcoholism or drug addiction;
- war, whether declared or undeclared;
- cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to trauma, infection or other diseases of the involved part; and reconstructive surgery because of congenital disease or anomaly of a covered Dependent Child which has resulted in functional defect;
- elective surgery not medically necessary, other than organ donation and complications related to organ donation after the appropriate Waiting Period;
- dental services or dental treatments unless necessitated by trauma or Injury;
- Injury or Sickness incurred as a result of being engaged as a paid athlete;
- participation in a riot, felony or insurrection;
- travel in, on or descending from any kind of aircraft, unless as a fare paying passenger on a commercial airline, passenger on a private airline charter or as a passenger on a privately owned and operated airplane that seats more than ten (10) passengers;
- sky diving;
- eye examinations, eye glasses, hearing aids or the fitting thereof; or
- care or treatment received outside of the United States or its territories.

The following which may be associated with or related to pregnancy are excluded from coverage under the Policy or Rider and no benefits are provided or paid for any care, treatment or claim related to:

- an elective abortion;
- false labor;
- occasional spotting;
- Physician prescribed rest; or
- morning sickness.

Complications of pregnancy will be treated the same as any other Sickness.

### RECEIPT FOR OUTLINE OF COVERAGE FOR POLICY FORM 90840 AR

Signature of Applicant	Date
Signature of Licensed Resident Agent	Date
THIS PORTION RETAINED BY APPLI	CANT
Form 1675 AR	Page 5
RECEIPT FOR OUTLINE OF COVERAGE FOR PO	LICY FORM 90840 AR
Signature of Applicant	Date
Signature of Licensed Resident Agent	Date

THIS PORTION RETAINED BY KANAWHA INSURANCE COMPANY





210 South White Street; Post Office Box 610 Lancaster, South Carolina 29721-0610 Telephone (Toll Free) 1-877-203-4249

## NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE

According to your application, you intend to lapse or otherwise terminate existing accident and health insurance, and replace it with a policy issued by *Kanawha Insurance Company*. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

- Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim may have been payable under your present policy.
- You may wish to secure the advice of your present insurer or its insurance producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure that you understand all relevant factors involved in replacing your present policy.
- If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for Kanawha to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

This <b>Notice to Applicant</b> was delivered to me on:								
Date	Signature of Applicant							

Original to Applicant; Copy to Home Office with Application

#### 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

Date

• 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 <i>Guide to Health Insurance for People with Medicare</i> available from Kanawha Insurance Company.
✓	For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

1131 10/03 Specified Diseases 71-62

Signature of Proposed Insured





## **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	
Na	ime		Month	Year
the sum of \$	being the payment of	mon	th(s) premium for the following	policies
				·
The insurance applied	for shall not take effect until:			
<ul> <li>the date of Policy,</li> <li>payment of the modern the Proposed Insured</li> </ul>	dal premium, and ed(s) has been approved for covera	age as applied.		
In the event the applic	ation is declined, any payment mad	de by the applica	nt will be returned.	
No coverage is prov	ided under this Conditional Rec	eipt unless the	conditions on this receipt a	re fulfilled.
No coverage is prov	ided for any claims that begin p	orior to the app	roval date.	
	ided under this Conditional Rec cation for insurance/ reinstate			d a material fact
No insurance produce receipt.	cer can waive or alter any of th	ne conditions o	r requirements stated on this	s conditional
Signature of Insu	urance Producer/Policy Administrato	or T	elephone Number of Insurance	Producer

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