Hospital Cash Plan

No one plans to get sick or injured. Be prepared if it happens to you.

HUMANA®
Guidance when you need it most

Humana Financial Protection Products

GCA06U3HH 10/09 MD

Hospital Cash Plan

Protect your savings from unexpected expenses.

In recent years, more than 40% of Americans have made an unexpected visit to an emergency room.* Your hard-earned savings could be at risk because of an accident or illness you have no way of predicting or preventing. Humana's **Hospital Cash Plan** is insurance that pays cash to you, or your designee, when you're sick or injured and need medical attention. Cash that can help pay for things your other insurance plans may not cover like copayments, deductibles, transportation expenses, and more … the choices are endless.

Even if you already have insurance, this plan pays you cash for:

- ✔ Emergency room treatment for accidental injury or sickness
- ✔ Benefits for hospital confinement and outpatient surgery

Base benefits

Lump Sum for Hospital Confinement – Five Policy Options				
$250	$500	$1,000	$1,500	$2,000
Maximum of one confinement for each insured per year				
Lump Sum for Accidental Injury and Sickness				
$150 for each Emergency Room visit		Within 72 hours of an accidental injury		
Maximum payments per year • Individual – 2 • Single Parent – 4 • Family – 6				
Lump Sum for Outpatient Surgery				
$150 for each Outpatient Surgery				
Paid per admittance/visit. For multiple surgeries within one admittance/visit, policy provides one cash payment.				
Maximum payments per year • Individual – 2 • Single Parent – 4 • Family – 6				

Optional benefits

Hospital Indemnity/ICU Daily Benefit Rider – Three Policy Options
• $50/day ($200/day if ICU) • $100/day ($400/day if ICU) • $200/day ($800/day if ICU)
Maximum of 30 days during a period of confinement resulting from injury or sickness, under the supervision of a physician, and beginning while rider is in force
Paid day one along with the lump-sum hospital confinement benefit
One period of confinement means one continuous hospital confinement or two or more hospital confinements for the same or related injury or sickness. All hospital confinements due to the same or related cause or causes shall be considered one and the same confinement unless periods of confinement resulting there from are separated by an interval of at least 180 consecutive days between the end of one such confinement and the beginning of a subsequent such confinement.

Policy limitations Covers certain pre-existing conditions after the first 12 months from the Date of Policy.

Hospital Cash Plan is Kanawha Insurance Company policy Form 90840 MD and optional rider policy Form 90841 MD. Limitations and exclusions apply. The benefits and riders offered are supplemental and not intended to cover all medical expenses. Please see actual policy for complete details. Underwritten by Kanawha Insurance Company – a member of the Humana family of companies.

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* U.S. Department of Health and Human Services, Advance Data, June, 2007.

Application for Hospital Indemnity

Kanawha Insurance Company

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Guidance when you need it most

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

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.)

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. Within the last 7 years 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. Within the last 7 years, 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 knowingly and willfully presents a false or fraudulent claim for payment of loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 _____ State
City

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

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 Grace Period 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 the Grace Period 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) ____ / ____ / ____