# Cash Cancer Plan - Sales Kit

Sale Kit Inlcudes the following:

-Application

-Conditional Receipt

-State Required Sales Forms

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# Application for Cash Cancer Plan
# Kanawha Insurance Company

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PLEASE INDICATE: ○ NEW COVERAGE ○ CHANGE TO EXISTING COVERAGE

## Proposed Insured (Please Print)

Person Proposed for Coverage (First Name, MI, Last Name) | Suffix

Birthdate (MM/DD/YYYY) | Social Security Number | Gender ○ Male ○ Female

Address (Street or R.R.)

City | State | ZIP Code | Home Telephone

Have you used Tobacco in any form in the last 12 months? ○ Yes ○ No

## Spouse

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

Birthdate (MM/DD/YYYY) | Social Security Number | Gender ○ Male ○ Female

Have you used Tobacco in any form in the last 12 months? ○ Yes ○ No

## Child One

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

Birthdate (MM/DD/YYYY) | Social Security Number | Gender ○ Male ○ Female

## Child Two

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

Birthdate (MM/DD/YYYY) | Social Security Number | Gender ○ Male ○ Female

## Child Three

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

Birthdate (MM/DD/YYYY) | Social Security Number | Gender ○ Male ○ Female



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**Child Four**

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

Birthdate (MM/DD/YYYY) / / Social Security Number - - Gender ○ Male ○ Female

**BENEFIT SECTION**

**Plan Type** ○ Individual (adult or child) ○ Single Parent (parent and all children)
○ Family (2 parents and all children) ○ Children Only (use single parent rate)

**Benefit** ○ $10,000 ○ $20,000 ○ $25,000 ○ $30,000 ○ $40,000 ○ $50,000

**Payment Period** ○ Lifetime Payment ○ Payment for 20 years **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

**Total Modal Premium** $ .
(Total modal premium must accompany application)

**PROPOSED INSURED'S REPRESENTATION AND AGREEMENT**

I hereby represent to Kanawha Insurance Company to the best of my knowledge, information and belief:

| | Proposed Insured | Spouse | Child 1 | Child 2 | Child 3 | Child 4 |
|---|---|---|---|---|---|---|
| | Yes/No | Yes/No | Yes/No | Yes/No | Yes/No | Yes/No |
| 1. Has any Proposed Insured ever been medically diagnosed as having, or been treated by a physician for: internal cancer, melanoma, leukemia, Hodgkin's Disease, malignant growth, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex, or tested positive for the Human Immunodeficiency Virus (HIV)? | ○ ○ | ○ ○ | ○ ○ | ○ ○ | ○ ○ | ○ ○ |
| 2. Will this policy replace any existing coverage? | ○ ○ | | | | | |

If "Yes", list company name, insured, and policy number.

_____

_____

3. I agree the policy will not be effective until it has actually been issued and understand no benefits are payable for a diagnosis of cancer in the first 30 days after the policy effective date.
4. I understand no Insurance Producer has the authority to waive the answer to any question in this Application, to waive any of the Company's rights or requirements or to make or alter any contract.
5. I understand any person who, with intent to defraud or knowing he/she is facilitating a fraud against any insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Signed At _____ City State

_____ Signature of Proposed Insured/Owner

/ / Date (MM/DD/YYYY)

## 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

## AUTHORIZATION FOR AUTOMATIC PAYMENT BY BANK DRAFT

## Attach Voided Check

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

Route & 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) ___ / ___ / ____

## INSURANCE PRODUCER'S USE

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

Date (MM/DD/YYYY)

Signature of Licensed Insurance Producer _____ ___ / ___ / ____

| Insurance Producer Number | % Credit | Insurance Producer Number | % Credit | Insurance Producer Number | % Credit |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

# 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

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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.