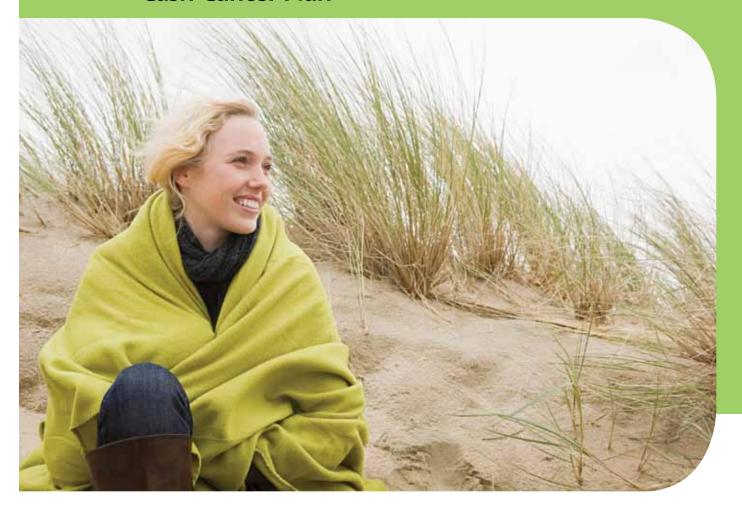
Cash Cancer Plan



No one plans to get cancer. Be prepared if it happens to you.



Humana Financial Protection Products

Cash Cancer Plan



Ensure financial peace of mind for you and your family.

One out of every two men and one out of every three women will get cancer.* That's a fact that should make you think. But instead of worrying, why not prepare? Humana's **Cash Cancer Plan** is a cancer insurance policy that pays cash to you, or your designee, to help with unexpected, out-of-pocket expenses.

If you or a member of your family is diagnosed with a covered cancer,** you'll receive a cash payment to use however you want. For instance, use it to help with:

- ✓ An unexpected loss of income
- ✓ Travel to national cancer centers
- ✓ Trial or experimental treatments
- ✔ Personal home care and household expenses

Cash Cancer Plan Features

	Choice of Who's Covered						
	Individual – Single Parent – Family						
	Benefit Amount						
	\$10,000	\$20,000	\$25,000	\$30,000	\$40,000	\$50,000	
	Two Payment Methods						
Pay premiur or until clair		ms for life of the policy m is filed.		Pay premiums for 20 years (without lapse). Coverage continues with no additional premiums required.			

Optional Return of Premium Rider

If there are no claims during the term of the rider, premiums will be refunded if the premiums are paid according to the following schedule:

- If the policy is issued when you're age 18-64, and you make no claims after 20 years of coverage, 100% of your premiums will be refunded.
- If the policy is issued when you're age 65-69, and you make no claims after 10 years of coverage, 50% of your premiums will be refunded.

Guidance when you need it most

Cash Cancer Plan is Kanawha Insurance Company policy Form 70130 MT and optional rider policy Form 70140. 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. Humana's Cash Cancer Plan is for protection in the event you are diagnosed with cancer in the future. Please do not apply for this plan if you have ever been diagnosed with cancer. No benefit is payable for a pre-existing condition within the first 12 months of policy issuance. Underwritten by Kanawha Insurance

Company – a member of the Humana family of companies.

^{*} Source: Cancer Facts & Figures 2009, American Cancer Society.

^{**} Covered cancer means first diagnosis and does not include skin cancer other than malignant melanoma.

Application for Cash Cancer Plan

Kanawha Insurance Company



PLEASE INDICATE: O NEW COVERAGE O CHANGE TO EXISTING COVERAGE					
Print)	Person Proposed for Coverage (First Name, MI, Last Name)	Suffix			
Insured (Please	Birthdate (MM/DD/YYYY) Social Security Number Gender O Male Address (Street or R.R.)	○ Female			
d Insure	City State ZIP Code Home Telephone				
Proposed	Have you used Tobacco in any form in the last 12 months? • Yes • No				
	Spouse Name (First Name, MI, Last Name) (If proposed for coverage)	Suffix			
မွ					
Spouse	Birthdate (MM/DD/YYYY) Social Security Number Gender O Male	○ Female			
	Have you used Tobacco in any form in the last 12 months? ○ Yes ○ No				
	Child Name (First Name, MI, Last Name) (If proposed for coverage)	Suffix			
Child One					
Chil	Birthdate (MM/DD/YYYY) Social Security Number Gender O Male	O Female			
	Child Name (First Name, MI, Last Name) (If proposed for coverage)	Suffix			
Child Two					
Chilc	Birthdate (MM/DD/YYYY) Social Security Number Gender O Male	○ Female			
	Child Name (First Name, MI, Last Name) (If proposed for coverage)	Suffix			
Child Three					
Child	Birthdate (MM/DD/YYYY) Social Security Number Gender O Male	Female			
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							•
$\overline{}$	Child Name (First Name, MI, Last Name) (If proposed for coverage)					Suffi	X
Four							
Б	Birthdate (MM/DD/YYYY) Social Security Number						
Child		Gend	der 🔾 N	1ale	○ Fema	ale	
BI	NEFIT SECTION						
Pl	an Type ○ Individual (adult or child) ○ Single Parent (parent	and all ch	ildren)				
 Family (2 parents and all children) Children Only (use single parent rate) 							
Ве	Benefit ○ \$10,000 ○ \$20,000 ○ \$25,000 ○ \$30,000 ○ \$40,000 ○ \$50,000						
Pa	yment Period ○ Lifetime Payment ○ Payment for 20 years	Return o	f Prem	ium 🔾	Yes	O No	
Pa	yment Method O Bank Draft O Credit Card O Direct Bill/Check (Annual				1		,
Da	(Complete Bank Draft or Credit Card Authorization. Annual fe vment Mode O Monthly O Semi-annual O Annual	e or \$12.	оо арр	lies to d	credit c	ard billi	ng.)
Pa	yment Mode ○ Monthly ○ Semi-annual ○ Annual						
To	tal Modal Premium \$.						
(10	tal modal premium must accompany application)						
	OPOSED INSURED'S REPRESENTATION AND AGREEMENT						
1 ne	ereby represent to Kanawha Insurance Company to the best of my knowledge			i beliet:			
	las any Proposed Insured ever been medically diagnosed as having, or been	Proposed Insured		Child 1	Child 2	Child 3	Child 4
	reated by a physician for: internal cancer, melanoma, leukemia, Hodgkin's Disease, malignant growth, Acquired Immune Deficiency Syndrome (AIDS),	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
P	IDS Related Complex, or tested positive for the Human Immunodeficiency						
	/irus (HIV)?Vill this policy replace any existing coverage?	0 0	0 0	0 0	0 0	0 0	0 0
	f "Yes", list company name, insured, and policy number.						
_							
_ 2 T							
	agree the policy will not be effective until it has actually been issued and inderstand no benefits are payable for a diagnosis of cancer in the first 30						
C	lays after the policy effective date.						
	understand no Insurance Producer has the authority to waive the answer to my question in this Application, to waive any of the Company's rights or						
r	equirements or to make or alter any contract.						
	understand any person who, with intent to defraud or knowing he/she is acilitating a fraud against any insurer, submits an application or files a claim						
	ontaining a false or deceptive statement may be guilty of insurance fraud.						
	Signed At						
	City State			_			
			1	1			
	Signature of Proposed Insured/Owner	Date (M	M/DD/	(YYY)	1		

1336 8/08 Page 2 6885118175

	T =				
	Payor Information (First, MI, Last Name) (If different than the Proposed Insured)	Suffix			
ر	Social Security Number				
Lio!					
nai	Address (Street or R.R.)				
orr	Address (Suree of fairt)				
Payor Information					
or	City State ZIP Code				
ay.					
	AUTHORIZATION FOR AUTOMATIC PAYMENT BY BANK DRAFT				
Attach Voided Check	Name of Depositor (First, MI, Last Name) (Attach Voided Check)	Suffix			
Che					
p					
ide					
%	Route & Transit Number Account Number				
t	Bank Name and Address				
 tta					
\bigcirc					
	on the day of the month (1-28 only; 29, 30, 31 not available). If no election is made, debits v	will be			
made on the day of Policy. As a convenience to me, I request and authorize KANAWHA INSURANCE COMPANY to make deductions automatically					
	payment period for payments of premiums from my: O savings account O checking account	,			
1 Fa	ch debit shall constitute proper notice of premium due and will be made on the day selected above or if no	day is			
	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.					
annually.					
6. Ka	nawha will notify me TEN (10) days prior to any changes in payment amounts.				
Signat	cure of Depositor Date (MM/DD/YYYY) / /				

	CF	REDIT CARD INFORMATION			
paym 1. Ea 2. Tl	Credit Card Number 3 or 4-digit security code found on the Signature of Card Holder Name as it appears on the credit of Card Holder (First Name, MI, Last Name) All charges convenience to me, I request and authorizent period for payment of premiums. The ach charge shall constitute proper notice this Authorization shall not become effective and authorization shall not become ef	Date (MM/DD/YYYY) Card statement. (If different from Proposed Insured) ne) Suffix Suffix Swill be made on the day of Policy. rize KANAWHA INSURANCE COMPANY to charge my credit card every			
 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. 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. Kanawha will notify me TEN (10) days prior to any changes in payment amounts. Signature of Card Holder					
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					
Insurar	nce Producer Number % Credit Ir	Insurance Producer Number % Credit			