Application for Hospital Indemnity
Kanawha Insurance Company

HUMANA
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]

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 _____ 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 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 SIXTY (60) 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 SIXTY (60) days prior to any changes in payment amounts.

Signature of Card Holder _____ Date (MM/DD/YYYY) ____ / ____ / ____