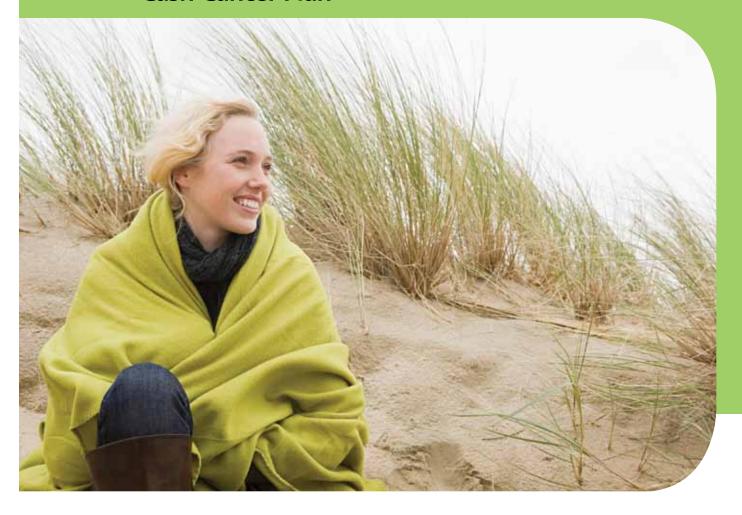
# **Cash Cancer Plan**

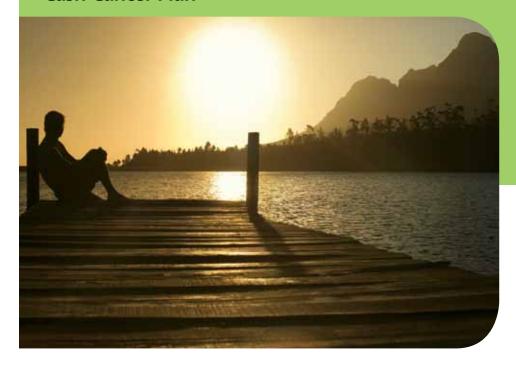


No one plans to get cancer. Be prepared if it happens to you.



**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 Cove	ered			
Individual -	Individual – Single Parent – Family				
Benefit An	nount				
\$10,000	\$20,000	\$25,000	\$30,000	\$40,000	\$50,000
Two Payme	ent Metho	ds			
Pay premiums for life of the policy or until claim is filed.			Pay premiums for 20 years (without lapse). Coverage continues with no additional premiums required.		

Cash Cancer Plan is Kanawha Insurance Company policy Form 70130 ND and optional rider policy Form 70145 2/10 ND. 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 24 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.

### **Optional Cash Value 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.

Cash values begin at end of fifth Policy Year. Upon lapse, proof of death or request to surrender Policy, you will receive the Cash Value Surrender Benefit if no First Diagnosis Cancer Benefit has been paid.



<sup>\*\*</sup> Covered cancer means first diagnosis and does not include skin cancer other than malignant melanoma.

## Application for Cash Cancer Plan

Child Three

# **Kanawha Insurance Company**



		•
PLEAS	E INDICATE: O NEW COVERAGE O CHANGE TO EXISTING COVERAGE	
Proposed Insured (Please Print)		Suffix
Spouse	Spouse Name (First Name, MI, Last Name) (If proposed for coverage)  Birthdate (MM/DD/YYYY)  Social Security Number  Gender O Male O Female  Have you used Tobacco in any form in the last 12 months? O Yes O No	Suffix
Child One	Child Name (First Name, MI, Last Name) (If proposed for coverage)  Birthdate (MM/DD/YYYY)  Social Security Number  Gender O Male O Fema	Suffix
Child Two	Child Name (First Name, MI, Last Name) (If proposed for coverage)  Birthdate (MM/DD/YYYY)  Social Security Number  Gender O Male O Fema	Suffix

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

Birthdate (MM/DD/YYYY)

Social Security Number

Gender Male Female

1336 8/08 ND

							•
$\overline{}$	Child Name (First Name, MI, Last Name) (If proposed for coverage)					Suffi	x
Four							
Щ. Т	Birthdate (MM/DD/YYYY)  Social Security Number						
Child		Geno	der 🔾 M	1ale	⊃ Fema	ale	
	BENEFIT SECTION						
F	Plan Type ○ Individual (adult or child) ○ Single Parent (parent ar		•				
	○ Family (2 parents and all children) ○ Children Only (use single	e parent	rate)				
E	<b>Benefit</b> ○ \$10,000 ○ \$20,000 ○ \$25,000 ○ \$30,000 ○ \$40,000 ○ \$	50,000					
F	Payment Period ○ Lifetime Payment ○ Payment for 20 years Cash Va	alue Ber	nefit R	ider 🔾	Yes	O No	
P	Payment Method			·			
Б	(Complete Bank Draft or Credit Card Authorization. Annual fee Payment Mode   Monthly   Semi-annual   Annual	e or \$12.0	ии аррі	ies to d	creait c	ard billi	ng.)
P	Payment Mode   Monthly   Semi-annual   Annual						
	Total Modal Premium \$						
	Total modal premium must accompany application)						
P	PROPOSED INSURED'S REPRESENTATION AND AGREEMENT						
I	hereby represent to Kanawha Insurance Company to the best of my knowledge, i	informati	ion and	belief:			
1		Proposed Insured	Spouse	Child 1	Child 2	Child 3	Child 4
	treated by a physician for: internal cancer, melanoma, leukemia, Hodgkin's					Yes/No	
	Disease, malignant growth, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex, or tested positive for the Human Immunodeficiency						
	Virus (HIV)?	0 0	0 0	0 0	0 0	0 0	0 0
2.	Will this policy replace any existing coverage?  If "Yes", list company name, insured, and policy number.	0 0					
	Tres , list company hame, insured, and policy humber.						
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						
5.	requirements or to make or alter any contract.  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						
		/	'	1			
	Signature of Proposed Insured/Owner	Date (Mi	M/DD/Y	YYY)			

	T = -4 (-1 ) (-2 ) (-2 )						
Payor Information	Payor Information (First, MI, Last Name) (If different than the Proposed Insured)	Suffix					
	Social Security Number						
E	Address (Street or R.R.)						
nfor							
or ]	City State ZIP Code						
Pay							
	AUTHORIZATION FOR AUTOMATIC PAYMENT BY BANK DRAFT						
४	Name of Depositor (First, MI, Last Name) (Attach Voided Check)	Suffix					
Che							
Attach Voided Check							
Voi	Route & Transit Number Account Number						
5	Bank Name and Address						
\tta							
Debit	on the day of the month (1-28 only; 29, 30, 31 not available). <b>If no election is made, debits v</b>	vill be					
made	e on the day of Policy.						
	convenience to me, I request and authorize <b>KANAWHA INSURANCE COMPANY</b> to make deductions autor payment period for payments of premiums from my: osavings account ochecking account	matically					
1 Fa	ach debit shall constitute proper notice of premium due and will be made on the day selected above or, if no	day is					
se	elected, the day of Policy.	udy is					
	nis Authorization shall not become effective unless and until the coverage is issued.  nis Authorization shall not be construed as modifying any provisions of the coverage.						
4. Ka	anawha shall not incur any liability if a draft is returned unpaid by the bank. Drafts which do not clear within						
	ipulated in the Policy for payment of premium shall constitute nonpayment of premiums and coverage shall ubject to nonforfeiture provisions.	iapse					
pr	nis Authorization may be discontinued by Kanawha or by the Undersigned at any time within FIVE (5) busine rior to the debit date. Upon termination of this Authorization, the premiums on the Policy covered will be pannually.						
	anawha will notify me TEN (10) days prior to any changes in payment amounts.						
	ture of Depositor Date (MM/DD/YYYY)						

	CREDIT CARD INFORMATION			
paym 1. Ea 2. Th 3. Th	dit Card Number  Expiration Date (MM/YY)  Card Type  Visa Mastercard  The as it appears on the credit card statement. (If different from Proposed Insured)  did Holder (First Name, MI, Last Name)  Suffix  All charges will be made on the day of Policy.  Interior to me, I request and authorize KANAWHA INSURANCE COMPANY to charge my credit card every eriod for payment of premiums.  Interior to me, I request and authorize of premium due.			
<ol> <li>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.</li> <li>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.</li> <li>Kanawha will notify me TEN (10) days prior to any changes in payment amounts.</li> </ol> Signature of Card Holder				
Signatu	INSURANCE PRODUCER'S USE  ny information recorded by me on this Application is true and accurate to the best of my knowledge and belief.  Date (MM/DD/YYYY)  Licensed Insurance Producer			
Insurar	roducer Number % Credit Insurance Producer Number % Credit Insurance Producer Number % Credit			