

Cash Cancer Plan - Sales Kit

Sale Kit Includes the following:

- Application
- Conditional Receipt
- State Required Sales Forms



Child Four

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

Suffix

Grid for child name and suffix

Birthdate (MM/DD/YYYY)

Social Security Number

Grid for birthdate and 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:

Table with 7 columns: Proposed Insured, Spouse, Child 1, Child 2, Child 3, Child 4. Rows contain questions about medical history, existing coverage, and policy terms.

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
	<input type="text"/>		<input type="text"/>
	Social Security Number		
	<input type="text"/> - <input type="text"/> - <input type="text"/>		
	Address (Street or R.R.)		
<input type="text"/>			
City		State	ZIP Code
<input type="text"/>		<input type="text"/>	<input type="text"/>

AUTHORIZATION FOR AUTOMATIC PAYMENT BY BANK DRAFT

Attach Voided Check	Name of Depositor (First, MI, Last Name) (Attach Voided Check)		Suffix
	<input type="text"/>		<input type="text"/>
	<input type="text"/>		<input type="text"/>
	Route & Transit Number	Account Number	
Bank Name and Address			
<input type="text"/>			

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

Four groups of four digit boxes for credit card number

Expiration Date (MM/YY)

Two digit boxes for month and two digit boxes for year

Card Type

Radio buttons for Visa and Mastercard

3 or 4-digit security code found on the back of most cards:

Three or four digit boxes for security code

Signature of Card Holder

Date (MM/DD/YYYY)

Month, day, and year boxes

Name as it appears on the credit card statement. (If different from Proposed Insured)

Card Holder (First Name, MI, Last Name)

Suffix

Grid of boxes for name and 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)

Month, day, and year boxes

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)

Month, day, and year boxes

Signature of Licensed Insurance Producer

Insurance Producer Number % Credit

Grid of boxes for insurance producer number and credit percentage

Insurance Producer Number % Credit

Grid of boxes for insurance producer number and credit percentage

Insurance Producer Number % Credit

Grid of boxes for insurance producer number and credit percentage

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

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