

Cash Cancer Plan - Sales Kit

Sale Kit Includes the following:

- Application
- Conditional Receipt
- State Required Sales Forms



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

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

Gender Male Female

Spouse

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

Birthdate (MM/DD/YYYY) Social Security Number

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

Gender Male Female

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

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

Birthdate input fields

Social Security Number input fields

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 understanding.

Signed At _____ City

State input box

Signature of Proposed Insured/Owner

Date input fields

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) with boxes for month, day, and year

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

Card Holder (First Name, MI, Last Name)

Suffix

Large 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) with boxes for month, day, and year

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)

Two digit boxes for month and two digit boxes for year

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

THE POLICY DESCRIBED IN THIS OUTLINE PROVIDES SUPPLEMENTAL COVERAGE

KANAWHA INSURANCE COMPANY

210 SOUTH WHITE STREET, POST OFFICE BOX 610

LANCASTER, SOUTH CAROLINA 29721-0610

TELEPHONE NUMBER: 877-378-1505

SUPPLEMENTAL FIRST DIAGNOSIS CANCER BENEFIT POLICY **Outline of Coverage for Form Number 70130 NM**

READ YOUR POLICY CAREFULLY! This Outline of Coverage provides a very brief description of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and the Company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

THIS IS NOT A MEDICARE SUPPLEMENT POLICY!

SUPPLEMENTAL FIRST DIAGNOSIS CANCER BENEFIT POLICY. The Policy is designed to supplement Your existing medical coverage. Coverage for the onset of a covered Cancer is provided to Insured Persons as outlined in **BENEFIT PROVISIONS**. The **PRE-EXISTING CONDITION LIMITATIONS PROVISION** as well as the **EXCEPTIONS AND LIMITATIONS PROVISION** exclude or limit coverage for certain losses. The Policy does not provide any benefits other than the stated amount for the First Diagnosis of Cancer.

CAUTION. The issuance of the Supplemental First Diagnosis Cancer Benefit Policy is based upon Your responses to the questions on Your Application. A copy of Your Application is attached to the Policy. If, to the best of Your knowledge and belief, there is any fraudulent misstatement in Your Application or if any past medical history has been omitted, Your Policy may not be a valid contract. The best time to clear up any questions is now, before a claim arises! If for any reason, any of Your answers are incorrect, contact Us.

TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND THE PREMIUM REFUNDED. After You receive Your Policy, take up to 30 days to examine Your Policy. If You are not completely satisfied, You may return it to Us within 30 days and receive a full refund of the Premium You paid.

AMOUNT OF BENEFITS. If an Insured Person receives a First Diagnosis of internal Cancer or malignant melanoma, We will pay the Supplemental First Diagnosis Cancer Benefit Amount shown on the Policy Schedule. No Supplemental First Diagnosis of Cancer Benefit Amount is payable for a diagnosis of skin Cancer other than malignant melanoma. The First Diagnosis must be after the Waiting Period and while the Policy is

in force with respect to the Insured Person. Each Insured Person is limited to one Supplemental First Diagnosis Cancer Benefit Amount under the terms of the Policy.

EXCEPTIONS AND LIMITATIONS. The Policy provides benefits only for First Diagnosis of internal Cancer or malignant melanoma. The Policy does not cover any other disease, sickness, incapacity, or injury. No benefit is payable for the diagnosis of skin Cancer other than malignant melanoma. Cancer First Diagnosed during the Waiting Period will not be a covered condition.

PRE-EXISTING CONDITION LIMITATIONS. The Policy does not cover Pre-existing Conditions for 24 months after the Date of Policy with respect to persons named in the Application for Insurance.

The Policy does not cover Pre-existing Conditions for 24 months after the effective date of coverage with respect to any Insured Person added after the Date of Policy.

Pre-existing Condition Limitations do not apply to Newborn Children or to Newly Adopted Children.

RENEWAL CONDITIONS. You may renew the Policy for life by paying each renewal Premium as it becomes due. Premiums are payable for life unless You choose the 20 Pay Option at the time of Application for the Policy. We do have the right to cancel the Policy for non-payment of Premium, the reasons stated in the Time Limit on Certain Defenses provision, and/or for the payment of the Supplemental First Diagnosis Cancer Benefit.

If the Supplemental First Diagnosis Cancer Benefit for an Insured Person has been paid, other Insured Persons may continue the Policy or purchase a Conversion Policy as outlined in the Termination of Coverage and Conversion of Coverage provisions of the Policy.

A child shall cease to be an Insured Person on his or her 25th birthday.

PREMIUM CHANGES. We reserve the right to change Premium rates. A change in the rates will apply to all policies of this form in Your state of residence. The change will be effective on the next Premium due date of Your Policy. If We change the rates, Your Premiums will be determined by Your Age on the Date of Policy. We will write to You, at the address shown in Our records, at least 45 days before We change Your Premium rate.

GRACE PERIOD. The Policy has a 31 day Grace Period. This means if a renewal Premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the Grace Period the Policy will stay in force.

YOUR TOTAL PREMIUM (AT TIME OF APPLICATION):

COVERAGE:

Individual

Single Parent

Family

The Supplemental First Diagnosis Cancer Benefit selected is:

\$10,000

\$20,000

\$25,000

\$30,000

\$40,000

\$50,000

The annual Premium amount for Policy 70130 NM is \$ _____ .

The modal Premium amount for Policy 70130 NM is \$ _____ .

The annual Premium amount for Rider 70140 Return of Premium is \$ _____ .

Total Annual Premium Payable \$ _____ .

Waiting Period. There is a 30 day Waiting Period following the Date of Policy, or the date an Eligible Dependent is added to the Policy, if later, during which no benefit amount will be paid. Cancer First Diagnosed during the Waiting Period will not be covered. There is no Waiting Period for Newborn Children or Newly Adopted Children.

RECEIPT FOR OUTLINE OF COVERAGE FOR POLICY FORM 70130 NM

Signature of Applicant

Date

Signature of Licensed Resident Agent

Date

THIS PORTION RETAINED BY APPLICANT

Form 1663 NM

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RECEIPT FOR OUTLINE OF COVERAGE FOR POLICY FORM 70130 NM

Signature of Applicant

Date

Signature of Licensed Resident Agent

Date

THIS PORTION RETAINED BY KANAWHA INSURANCE COMPANY

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