Critical Illness Cash - Sales Kit

Sale Kit Inlcudes the following:

-Application

-Conditional Receipt

-State Required Sales Forms

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Humana Financial Protection Products

GCA08IFHHOK

Application for Critical Illness Insurance
Kanawha Insurance Company

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PLEASE INDICATE: ○ NEW COVERAGE ○ CHANGE TO EXISTING COVERAGE ○ CONTINUATION OF COVERAGE

Person(s) Proposed for Coverage

Primary Insured (Please Print)

First Name | MI | Last Name | Suffix

Birthdate (MM/DD/YYYY) / / | State of Birth | Height (Ft-In) - | Weight | Social Security Number - -

Address (Street or R.R.)

Gender ○ Male ○ Female

City | State | ZIP Code | Home Telephone ( ) -

Have you used any form of tobacco in the past 12 months?..... ○ Yes ○ No

Spouse

Spouse Name (First Name, MI, Last Name) (If proposed for coverage) | Suffix | State of Birth

Birthdate (MM/DD/YYYY) / / | Height (Ft-In) - | Weight | Social Security Number - -

Gender ○ Male ○ Female

Have you used any form of tobacco in the past 12 months?..... ○ Yes ○ No

Child One

Child Name (First Name, MI, Last Name) (If proposed for coverage) | Suffix | State of Birth

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 | State of Birth

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 | State of Birth

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) ○ Couple [(Individual and spouse/partner)]
○ Family (2 parents and all children) ○ Single Parent (Parent and all children)

Base Plan (Select Only One) ○ Vascular, Cancer and Other Illnesses ○ Vascular and Other Illnesses ○ Cancer Only

Primary Insured/Spouse Benefit Amount: $ ___,___

Child(ren) Benefit Amount: $ ___,___

Total Modal Premium: $ ___.__

Optional Benefit: 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

Beneficiary:

○ 100% to my Spouse, as recorded on Page 1 of this Application

○ Other (List name, relationship and percentage share) _____

_____

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. In the last 12 months, has any Person Proposed for Coverage:					
a. Been unable to perform their normal duties at work, home or school on a full-time basis due to an illness or disability?	○ ○	○ ○	○ ○	○ ○	○ ○
b. Missed more than 5 consecutive days of work or school due to an illness or injury?	○ ○	○ ○	○ ○	○ ○	○ ○
2. Has any Person Proposed for Coverage ever been treated for or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or tested positive for the antigens or antibodies to an AIDS (HIV) virus?	○ ○	○ ○	○ ○	○ ○	○ ○
3. In the 6 months prior to the Application date, has any Person Proposed for Coverage been hospitalized as an inpatient or treated on an outpatient basis, except for minor injuries or normal pregnancy?	○ ○	○ ○	○ ○	○ ○	○ ○
4. Has any Person Proposed for Coverage ever been diagnosed with or treated for drug abuse or alcohol abuse, disease of the liver, kidney or digestive system, disease or disorder of the lung, diseases of the nervous system, including Parkinson's, multiple sclerosis, cerebral palsy, hemiplegia, paraplegia, quadriplegia, or any disease or disorder which has led or may lead to a permanent or progressive loss of vision or speech?	○ ○	○ ○	○ ○	○ ○	○ ○
5. Has any Person Proposed for Coverage ever been diagnosed with or treated for heart disease, including angina, heart attack, congestive heart failure, heart bypass, cerebrovascular disease including Transient Ischemic Attack (TIA), stroke (blockages or hemorrhage), diabetes, or blood pressure readings above the normal range which have not been controlled with medication?	○ ○	○ ○	○ ○	○ ○	○ ○
6. Has any Person Proposed for Coverage ever been diagnosed with or treated for Cancer, including melanoma, leukemia, lymphoma, malignant tumors, or skin cancers?	○ ○	○ ○	○ ○	○ ○	○ ○
7. To the best of your knowledge and belief, have any two of your natural parents or natural siblings (sisters or brothers) been diagnosed with the same disease before age 60 based on the following list:					
a. Vascular: heart attack, heart disease or stroke?	○ ○	○ ○	○ ○	○ ○	○ ○
b. Cancer: cancer?	○ ○	○ ○	○ ○	○ ○	○ ○
c. Other: kidney disease, diabetes?	○ ○	○ ○	○ ○	○ ○	○ ○

8. Does any Person Proposed for Coverage have any other Critical Illness 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.

9. 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

WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

I/We have read or had read to me all the questions on this Application and I/We represent the answers and any information provided are correct and complete to the best of my knowledge and belief. I/We 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/We understand and agree that the policy will not take effect unless it is issued by Kanawha Insurance Company, the total modal premium must accompany the 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/We acknowledge, if required in my state, that I/We have been furnished:

☐ Outline of Coverage ☐ Medicare Buyer's Guide (If age 65 or over) ☐ MIB Disclosure Notice

AUTHORIZATION

By this form (or photocopy of it), which is valid for 24 months from the date shown below, I/We authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, pharmacy, pharmacy benefit manager or other pharmacy related services organization, insurance company, the Medical Information Bureau, or other person, organization, or institution, that has any records or knowledge of me, my spouse or my child(ren) for whom insurance Application is made, or my health, my spouse's or my child(ren)'s health, to give to Kanawha Insurance Company, or its reinsurers, any such information and to testify as to such information, all to the extent permitted by law. I understand that such information will be used by Kanawha Insurance Company for the purpose of evaluating my Application for insurance.

I/We understand that I/We have the right to revoke this Authorization in writing, at any time, by providing written request for revocation to: Kanawha Insurance Company at 210 South White Street, Lancaster, SC 29720, Attention: Underwriting Department. I/We understand that a revocation is not effective to the extent that Kanawha Insurance Company has relied upon information disclosed prior to the revocation. I/We understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

Signed At _____ State

/ / Date (MM/DD/YYYY)

Signature of Applicant/Owner/Primary Insured

Signature of Spouse (If Proposed for Coverage)

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 TEN (10) days prior to any changes in payment amounts.

Signature of Depositor _____ Date (MM/DD/YYYY) ____ / ____ / ____

Card Holder Information

CREDIT CARD 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: ____

Name as it appears on the credit card (If different than 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 TEN (10) days prior to any changes in payment amounts.

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

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

DETACH AND GIVE THIS PAGE TO PROPOSED INSURED

MIB Disclosure Notice - Detach and Give to Proposed Insured

Information regarding your insurability will be kept confidential. Kanawha Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, email address www.mib.com and telephone number (781) 751-6000. Kanawha Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

NOTICE TO PROPOSED INSURED

Thank you for giving Kanawha the opportunity to consider your insurance needs. As part of our normal procedure for processing Applications, we may order an investigative consumer report. This includes your prescription drug history and information as to your character, general reputation, personal characteristics, and mode of living. The information obtained in such investigative consumer report will not be used to make a determination of your sexual preference. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation. You may request to be interviewed in connection with the preparation of this investigative consumer report and upon request you are entitled to receive a copy of the investigative consumer report. If you question the accuracy of information in the investigative consumer report, you may contact the Consumer Reporting Agency and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. We may telephone you to confirm information given in your Application or to obtain additional information needed to process your Application. All information asked for in your Application, or obtained from other sources, such as your physician, or hospitals where you have been treated, is for the sole purpose of determining your acceptability for the insurance coverage for which you have applied. All information obtained will be kept confidential. Upon your written request, we will furnish you or your physician with the nature or source of the information.

KANAWHA INSURANCE COMPANY

[210 S. WHITE STREET]
[LANCASTER, SC 29720]

[PO BOX 610]
[LANCASTER, SC 29721-0610]

TELEPHONE: [877-207-0158]

OUTLINE OF COVERAGE
FOR CRITICAL ILLNESS POLICY FORM 70620 OK

A LIMITED BENEFITS POLICY

PLEASE READ YOUR POLICY CAREFULLY. This Outline of Coverage provides a very brief description of some of the important features of Your Policy. This is not the insurance contract. Only the actual Policy terms will control. The Policy itself states the rights and duties of both You and Kanawha Insurance Company ("Kanawha"). The Policy also states the benefits and requirements. It is therefore important that **YOU READ YOUR POLICY CAREFULLY!** Please contact Us if You have questions.

LIMITED BENEFITS COVERAGE. Policies of this type are designed to provide covered persons with limited or supplemental coverage. The Benefits Summary section below outlines the coverage provided by the Policy. Benefits described in the Benefits Summary may be limited by the Conditions and Limitations, Waiting Period and Exclusions sections, and other terms in Your Policy.

NO RECOVERY FOR PRE-EXISTING CONDITIONS. No benefits will be provided during the first 12 months of the Policy and any attached Rider for any Pre-existing Condition. The term Pre-existing Condition is:

- defined in the Policy; and
- may be added to or changed in a Policy Rider.

POLICY BENEFITS SUMMARY

Critical Illness Lump Sum Benefit. We will pay a lump sum percentage of the Face Amount to the Policy Owner when a Covered Person suffers from a covered Critical Illness.

Coverage shown is only effective if approved by Us. If coverage is approved by Us, it will be made effective at 12:01 a.m. local time in the Covered Person's state of residence on the date We approved it.

Face Amounts are:
(Check persons applied for.)

☐ For Primary Insured [$#,###.##]

☐ For Spouse [If applied for, same a Primary Insured]

☐ For Children [$#,###.##]

The Face Amount reduces by 50% when a Covered Person reaches Age 70.

A set of Critical Illnesses is called a Benefit Group. Based on Your application to Us and Our approval, Your Policy will cover the [Vascular][,] [and] [Cancer][and] [Other Critical Illnesses] Benefit Group[s]. [This][These] Benefit Group[s] [is][are] summarized below.

Benefits shown are only effective if approved by Us.

Benefit Groups
(Check those applied for.)

☐ [Vascular:

Heart Attack	[100%] of Face Amount
Heart Transplant	[100%] of Face Amount
Stroke	[100%] of Face Amount
Coronary Artery Bypass Surgery	[25%] of Face Amount]

☐ [Cancer:

Invasive Cancer or Malignant Melanoma	[100%] of Face Amount
Carcinoma in Situ	[25%] of Face Amount]

☐ [Other Critical Illnesses:

Major Organ Transplant	[100%] of Face Amount
End Stage Renal Failure	[100%] of Face Amount
Loss of Speech or Vision	[100%] of Face Amount
Coma	[100%] of Face Amount]
Permanent Paralysis due to Accidental Injury	[100%] of Face Amount]

Each Critical Illness is defined in the Policy.

For each Covered Person during the entire time that the Policy is in force:

[• payment of Benefits within a Benefit Group will not exceed [100%] of the Face Amount[;][.]]
[• payment of Benefits within the [Vascular] [and] [Cancer] Benefit Group[s] will not exceed [100%] of the Face Amount[.][;][and]

[• payment of Benefits within the Other Critical Illnesses Benefit Group will not exceed [50%] of the Face Amount.]

GUARANTEED RENEWABLE. You can keep the Policy during the Primary Insured's lifetime. You must pay each Premium due before the end of the Grace Period. Your Premium can be changed, if We change the Premium on all policies in Your Policy's Premium class. Premiums may also vary based on Your state of residence.

Insurance on a Covered Person ends when We have paid 100% of the Face Amount in each Benefit Group covering that person.

PREMIUM. Your first Premium is [$###.##]. Your renewal Premium is stated below. Your Premium is subject to change as outlined above and as stated in Your Policy.

Payment Mode: ☐ Monthly Direct ☐ Monthly Bank Draft ☐ Quarterly ☐ Semi-Annual ☐ Annual
Modal Premium: $[_____]

[Notice: A collection fee of [$12.00] annually will be applied to all policies billed by credit card. This fee may be changed annually.]

If You have Rider coverage under Your Policy, it is included in the above stated Premium.

GRACE PERIOD. A Grace Period of 31 days is provided for payment of each Premium due, except for the first Premium. Coverage will remain in force during the Grace Period.

BENEFIT CONDITIONS AND LIMITATIONS

The following will apply to the policy. For each Covered Person —

Any loss due to a Pre-existing Condition will not be covered if the loss begins within [12] months after his or her Effective Date.

When a named Critical Illness is contributed to or caused by another named Critical Illness, We will pay only one Benefit. The Benefit paid will be the larger. If the Benefits are equal, the Policy Owner may choose the Benefit to be paid.

A Critical Illness that occurs during the 30-day period after his or her Effective Date is not covered.

[A Tentative, Clinical or Pathological Diagnosis of Invasive Cancer during the 30-day period after his or her Effective Date is not covered.]

[Benefits for Invasive Cancer or Carcinoma in Situ will not be payable based on a Tentative Diagnosis.]

[All Vascular Benefits end when We have paid [100%] of his or her Face Amount for any of the following:

- Heart Attack;
- Heart Transplant; [or]
- Stroke.]

[When We pay a Benefit for Coronary Artery Bypass Surgery, his or her Face Amount for other Vascular Benefits is reduced by [25%].]

[All Cancer Benefits end when We have paid [100%] of his or her Face Amount for Invasive Cancer.] [When We pay a Benefit for Carcinoma in Situ, his or her Face Amount for Invasive Cancer is reduced by [25%].]

[All Other Critical Illness Benefits end when We have paid [100%] of his or her Face Amount for any of the following:

- Major Organ Transplant;
- End Stage Renal Disease;
- Loss of Vision or Speech;
- Coma; or
- Permanent Paralysis.]

WAITING PERIOD

A loss otherwise insured by the Policy is not covered if it occurs within 30 days after a Covered Person's Effective Date.

EXCLUSIONS

The following will apply to the policy.

No Benefits of the Policy or Riders attached to it will be paid for loss that is contributed to, caused by, or occurs during:

- any intentionally self-inflicted Injury;
- suicide, or attempted suicide, while sane or insane;
- active duty military service;
- participation in the commission or attempted commission of a felony; or
- alcoholism or drug addiction.

Upon receipt of written notice of military service, We will refund of premiums as applicable to such Covered Person on a pro rata basis while such Covered Person is serving in the military.

[☐ OPTIONAL RETURN OF PREMIUM BENEFIT RIDER (FORM 70622) (Check if applied for.)

Return of Premium Benefit

We will return all Premiums paid on the Policy and Riders attached to it on the 20th anniversary of the Date of Policy if:

- Premiums of the Policy are paid to the 20th anniversary of the Date of Policy;
- this Rider is then in force; and
- **no claim for** a Critical Illness Benefit has been paid or incurred.

On the second and any later 20-Year Anniversary, We will return all Premiums paid on the Policy and Riders attached to it since the prior 20-Year anniversary if:

- Premiums of the Policy are paid to the then current 20-Year Anniversary;
- this Rider is then in force; and
- no claim for a Critical Illness Benefit has been paid or incurred.

We will pay any Return of Premium Benefit to You.

After a Return of Premium Benefit is paid, You can keep the Policy, this Rider and any other Riders by paying the Premiums for them.

Rider Limitations

If any Critical Illness Benefit is paid for a Covered Person of the Policy, this Rider ends.

If this Rider ends, no Return of Premium Benefit will be payable on any 20-Year Anniversary that takes place after this Rider ends.]

RECEIPT FOR OUTLINE OF COVERAGE FOR POLICY FORM 70620 OK

Signature of Applicant **Date**

Signature of Licensed Resident Agent **Date**

THIS PORTION RETAINED BY APPLICANT

1678 OK

RECEIPT FOR OUTLINE OF COVERAGE FOR POLICY FORM 70620 OK

Signature of Applicant **Date**

Signature of Licensed Resident Agent **Date**

THIS PORTION RETAINED BY KANAWHA INSURANCE COMPANY

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Guidance when you need it most

KANAWHA
INSURANCE COMPANY

210 South White Street; Post Office Box 610
Lancaster, South Carolina 29721-0610
Telephone (Toll Free) 1-877-203-4249

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE

According to your application, you intend to lapse or otherwise terminate existing accident and health insurance, and replace it with a policy issued by *Kanawha Insurance Company*. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1 Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim may have been payable under your present policy.

2 You may wish to secure the advice of your present insurer or its insurance producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure that you understand all relevant factors involved in replacing your present policy.

3 If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for Kanawha to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

This **Notice to Applicant** was delivered to me on:

_____ _____

Date Signature of Applicant

Original to Applicant; Copy to Home Office with Application

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

KANAWHA INSURANCE COMPANY

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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

[210 South White Street, Lancaster SC 29720
Mail: Post Office Box 7777, Lancaster SC 29721-7777 1-877-378-1505]
Kanawha Insurance Company is a member of the Humana family of companies.