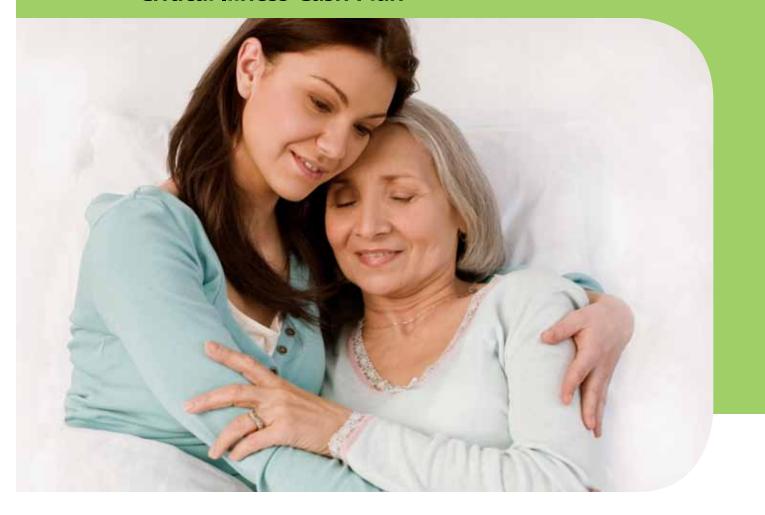
Critical Illness Cash Plan



A heart attack doesn't have to be financially devastating, if you're prepared.



Humana Financial Protection Products

Critical Illness Cash Plan



Protect yourself and your family from the costs of critical illness.

Every 34 seconds someone in the United States suffers a heart attack.* Are you financially prepared if it's you? A heart attack, stroke, cancer, or other serious illness often comes without warning. The **Critical Illness Cash Plan** is insurance that helps protect you, your family, and your assets from unexpected expenses.

If you or a member of your family is diagnosed with a covered critical illness, you or your designee will receive a cash payment to use however you want. For instance, use it to help with:

- ✓ An unexpected loss of income
- ✓ Out-of-pocket medical costs and travel for medical care
- ✔ Home healthcare and rehabilitation expenses

Summary of benefits

Vascular

- ✔ Heart attack
- ✓ Heart transplant as a result of heart failure
- ✓ Stroke
- ✓ Coronary artery bypass surgery (25% benefit)

Cancer

- ✔ First diagnosis of invasive cancer or malignant melanoma
- ✓ Carcinoma In-situ (25% benefit)

Other

- ✓ Major organ transplant, other than heart
- ✓ End-stage renal failure
- ✓ Loss of sight
- ✓ Loss of speech
- ✓ Coma (excluding vascular and cancer conditions)
- ✔ Permanent paralysis due to an accident

Example: Critical Illness Cash Plan – \$50,000 benefit level

Diagnosed Covered Condition [This is one example. See the Summary of Benefits for other covered conditions.]	Cash Payment
You have a heart attack	\$50,000
You're later diagnosed with cancer	\$50,000
You eventually need a transplant	\$50,000
Total Benefit	\$150,000

And you get even more security with the optional Return of Premium and Cash Value Rider.

If you continue to pay your premiums (with no lapse in coverage) and don't file a claim, you'll receive a full refund of all premiums paid on the policy's 20-Year Anniversary.

Cash values begin at the end of the fifth Policy Year. Upon lapse, proof of death or request to surrender the Policy, you will receive the Cash Value Benefit if no claim for Critical Illness Benefit has been paid or incurred.

Critical Illness Cash Plan is Kanawha Insurance Company policy Form 70620 and optional rider policy Form 70623. Limitations and exclusions apply. Benefits may vary by state and may not be approved in all states. Benefits reduce by 50% at age 70. The benefits and riders offered are supplemental and not intended to cover all medical expenses. Covered cancer means first diagnosis and does not include skin cancer other than malignant melanoma. Please see actual policy for complete details. No benefit is payable for a pre-existing condition within the first 12 months of policy issuance. Underwritten by Kanawha Insurance Company – a member of the Humana family of companies. * Source: 2009 Heart Disease & Stroke Statistics, American Heart Association



Application for Critical Illness Insurance

Kanawha Insurance Company



		•
		ON OF COVERAGE
	n(s) Proposed for Coverage	Cuffin
Print)	First Name MI Last Name	Suffix
<u> </u>		
ase	Birthdate (MM/DD/YYYY) State of Birth Height (Ft-In) Weight Social Security	[,] Number
Pe		-
Primary Insured (Please	Address (Street or R.R.)	Gender
ure		O Male O Female
[ns	City State ZIP Code Home Telephone	or late
ma		
Pri	Have you used any form of tobacco in the past 12 months?	········· O Yes O No
	Spouse Name (First Name, MI, Last Name) (If proposed for coverage)	Suffix State of Birth
lω		
Spouse	Birthdate (MM/DD/YYYY) Height (Ft-In) Weight Social Security Number	Gender
Spc	, , , , , , , , , , , , , , , , , , ,	O Male O Female
	Have you used any form of tobacco in the past 12 months?	O Yes O No
(4)	Child Name (First Name, MI, Last Name) (If proposed for coverage)	Suffix State of Birth
Child One		
<u>p</u>	Birthdate (MM/DD/YYYY) Height (Ft-In) Weight Social Security Number	Gender
S.		○ Male ○ Female
\subseteq		
9	Child Name (First Name, MI, Last Name) (If proposed for coverage)	Suffix State of Birth
Child Two		
) ild	Birthdate (MM/DD/YYYY) Height (Ft-In) Weight Social Security Number	Gender
ַ		O Male O Female
		Suffix State of Birth
l ree	Child Name (First Name, MI, Last Name) (If proposed for coverage)	Suffix State of Birth
 		
Child Three	Birthdate (MM/DD/YYYY) Height (Ft-In) Weight Social Security Number	Gender
Ö		O Male O Female
	.677	5940209346

Plan Type ○ Individual (Adult)	er)]					
· · · · · · · · · · · · · · · · · · ·	/ _					
reaconvery nacions and an convincion — U Single Parent (Parent and all Children)		· / · · · · · · /-				
Base Plan (Select Only One) Vascular, Cancer and Other Illnesses Vascular and Other Ill		· O	Cancor	Only		
			al Prem			
Primary Insured/Spouse Benefit Amount Child(ren) Benefit Amount	TOLO	ai Moud	ı Pieiii			
\$, , ;	\$					
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 appl	lies to	credit	card b	illing.)]		
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						
1. In the last 12 months, has any Person Proposed for Coverage: Insured S	pouse	Child 1	Child 2	Child 3		
	'es/No	Yes/No	Yes/No	Yes/No		
basis due to an illness or disability?	0 0	0 0	00	0 0		
b. Missed more than 5 consecutive days of work or school due to an illness or						
	0 0	0 0	0 0	0 0		
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						
and the disease are ATDC (LTLV) visus 2	0 0	0 0				
3. In the 6 months prior to the Application date, has any Person Proposed for Coverage		0 0				
been hospitalized as an inpatient or treated on an outpatient basis, except for minor						
	0 0	0 0	00	0 0		
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?	0 0	0 0	00			
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?	0 0	00	00	0 0		
6. Has any Person Proposed for Coverage ever been diagnosed with or treated for						
Cancer, including melanoma, leukemia, lymphoma, malignant tumors, or skin						
cancers?	0 0	0 0	00	0 0		
natural siblings (sisters or brothers) been diagnosed with the same disease before						
age 60 based on the following list:						
	0 0	0 0	00	0 0		
b. Cancer: cancer?	0 0	0 0	0 0	0 0		
c. Other: kidney disease, diabetes?	0 0	0 0	00	00/		

1	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?
	Will the policy applied for replace any coverage currently in force?
	Payor Information (First, MI, Last Name) (If different than the Proposed Insured) Suffix
Payor Information	
yor In	City Chats 77D Code
Pa	City State ZIP Code
	y Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, bmits an Application or files a claim containing a false or deceptive statement may be subject to prosecution
prov misr Inco Kan- card ques	The have read or had read to me all the questions on this Application and I/We represent the answers and any information wided are correct and complete to the best of my knowledge and belief. I/We also realize that any false statements or representation may result in loss of coverage under the policy subject to the Time Limit on Certain Defenses or ontestability provisions of the policy. I/We understand and agree that the policy will not take effect unless it is issued by awha Insurance Company, the total modal premium must accompany the Application, and any check, bank draft or credit dipayment is honored on first presentation. No agent or producer has the authority to waive any of the conditions or stions 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
phys man pers App reins	this form (or photocopy of it), which is valid for 30 months from the date shown below, I/We authorize any licensed sician, medical practitioner, clinic, hospital, or other medical or medically related facility, pharmacy, pharmacy benefit mager or other pharmacy related services organization, insurance company, the Medical Information Bureau, or other son, organization, or institution, that has any records or knowledge of me, my spouse or my child(ren) for whom insurance dication is made, or my health, my spouse's or my child(ren)'s health, to give to Kanawha Insurance Company, or its surers, any such information and to testify as to such information, all to the extent permitted by law. I understand that in information will be used by Kanawha Insurance Company for the purpose of evaluating my Application for insurance.
I/We revo Dep upor Auth	e understand that I/We have the right to revoke this Authorization in writing, at any time, by providing written request for ocation to: Kanawha Insurance Company at 210 South White Street, Lancaster, SC 29720, Attention: Underwriting partment. I/We understand that a revocation is not effective to the extent that Kanawha Insurance Company has relied in information disclosed prior to the revocation. I/We understand that any information that is disclosed pursuant to this horization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health rmation.
Sig	State Date (MM/DD/YYYY) Signature of Applicant/Owner/Primary Insured Signature of Spouse (If Proposed for Coverage)
	E.g. Etta. 5 . Applicating 5

1677 Page 3 2950209344

		AUTHORIZATION FOR AUTOMATIC PAYMENT BY BANK DRAFT	•	1
(왕		Name of Depositor (First, MI, Last Name) (Attach Voided Check)	Suffix	
Attach Voided Check				
р				
ide				
9		Route and Transit Number Account Number		
C		Bank Name and Address		
tta				
<u> </u>				
Г	۵h	oit on the day of the month (1-28 only; 29, 30, 31 not available). If no election is made, debits	s will ha	
		de on the day of Policy.	, will be	
		a convenience to me, I request and authorize KANAWHA INSURANCE COMPANY to make deductions au	tomaticall	У
		ry payment period for payments of premiums from my: O savings account O checking account Each debit shall constitute proper notice of premium due and will be made on the day selected above or, if I	no dav is	
	:	selected, the day of Policy.	,	
		This Authorization shall not become effective unless and until the coverage is issued. This Authorization shall not be construed as modifying any provisions of the coverage.		
		Kanawha shall not incur any liability if a draft is returned unpaid by the bank. Drafts which do not clear with	nin the tim	ne
		stipulated in the Policy for payment of premium shall constitute nonpayment of premiums and coverage shall be stipulated in the Policy for payment of premium shall constitute nonpayment of premiums and coverage shall be stipulated in the Policy for payment of premium shall constitute nonpayment of premiums and coverage shall be stipulated in the Policy for payment of premium shall constitute nonpayment of premiums and coverage shall be stipulated in the Policy for payment of premium shall be stipulated in the Policy for payment of premium shall be stipulated in the Policy for payment of premium shall be stipulated in the Policy for payment of premium shall be stipulated in the Policy for payment of premium shall be stipulated in the Policy for payment of premium shall be stipulated in the Policy for payment of premium shall be stipulated in the Policy for payment of premium shall be stipulated in the Policy for payment of premium shall be stipulated in the Policy for payment of premium shall be stipulated in the Policy for payment of premium shall be stipulated in the Policy for payment of premium shall be still be stil	all lapse	
5		subject to nonforfeiture provisions. This Authorization may be discontinued by Kanawha or by the Undersigned at any time within FIVE (5) busi	ness davs	
J		prior to the debit date. Upon termination of this Authorization, the premiums on the Policy covered will be		
_		annually.		
0	. r	Kanawha will notify me TEN (10) days prior to any changes in payment amounts.		
S	ign	nature of Depositor Date (MM/DD/YYYY) // // //		
				\
ormation		CREDIT CARD INFORMATION Credit Card Number Expiration Date (MM/YY)		,
hat		Card Typ		
9		Ulling the state of the state	stercard	
Card Holder Info		3 or 4-digit security code found on the back of most cards:		
der				
9		Name as it appears on the credit card (If different than Proposed Insured) Card Holder (First Name, MI, Last Name)	Suffix	
<u>5</u>			1	
S				
	_	All charges will be made on the day of Policy. convenience to me, I request and authorize KANAWHA INSURANCE COMPANY to charge my credit care		
		nent period for payment of premiums.	J every	
1.	E	Each charge shall constitute proper notice of premium due.		
		This Authorization shall not become effective unless and until the Policy is issued. This Authorization shall not be construed as modifying any provisions of the Policy.		
3. 4.		Kanawha shall not incur any liability if the credit card company does not honor the charge and the Policy sha	II lapse	
_	S	subject to nonforfeiture provisions.	·	
5.		This Authorization may be discontinued by Kanawha or by the undersigned at any time within FIVE (5) busing days prior to the payment date. Upon termination of this Authorization, premiums for the Policy will be payal		llv,
6.		Canawha will notify me TEN (10) days prior to any changes in payment amounts.	ווועם איר ai ii ludi	пу.
Sid	ากล	ature of Card Holder Date (MM/DD/YYYY)		,
\ -::	,			

FOR INSURANCE PRODUCER'S USE ONLY

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.