Hospital Cash - Sales Kit

Sale Kit Inlcudes the following:

-Application

-Conditional Receipt

-State Required Sales Forms

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GCA08IBHHKS

Application for Hospital Indemnity
Kanawha Insurance Company

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PLEASE INDICATE: ○ NEW COVERAGE ○ CHANGE TO EXISTING COVERAGE ○ CONVERSION

Person(s) Proposed for Coverage

Primary Insured (Please Print)

First Name | MI | Last Name | Suffix

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

Address (Street or R.R.)

City | State | ZIP Code

Home Telephone ( ) -

Spouse

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

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

Child One

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

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

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

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 or child) ○ Family (2 parents and all children) ○ Single Parent (parent and all children)

Base Benefit ○ $250 ○ $500 ○ $1,000 ○ $1,500 ○ $2,000

Optional Benefit: Hospital Confinement Daily Benefit Rider / Intensive Care Unit (ICU) Daily Benefit

○ $50/day ($200/day if ICU) ○ $100/day ($400/day if ICU) ○ $200/day ($800/day if ICU)

Payment Method ○ Bank Draft ○ Credit Card ○ Direct Bill/Check (Annual Billing Only)
(Complete Bank Draft or Credit Card Authorization.)

Payment Mode ○ Monthly ○ Semi-annual ○ Annual **Total Modal Premium** $ ___ . ___

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. Has anyone proposed for coverage ever been diagnosed or treated by a member of the medical profession as having:					
a. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive to the antibodies for Human Immunodeficiency Virus (HIV)	○ ○	○ ○	○ ○	○ ○	○ ○
b. Alzheimer's Disease	○ ○	○ ○	○ ○	○ ○	○ ○
c. Senile dementia	○ ○	○ ○	○ ○	○ ○	○ ○
d. Uncorrected congenital heart defect (excluding mitral valve prolapse)	○ ○	○ ○	○ ○	○ ○	○ ○
e. Kidney disease (not including kidney stones)	○ ○	○ ○	○ ○	○ ○	○ ○
f. Systemic lupus	○ ○	○ ○	○ ○	○ ○	○ ○
g. Insulin-dependent diabetes	○ ○	○ ○	○ ○	○ ○	○ ○
h. Liver disease or disorder (excluding Hepatitis A)	○ ○	○ ○	○ ○	○ ○	○ ○
2. a. Is any person proposed for coverage currently confined in a hospital, nursing home, or any medical facility?	○ ○	○ ○	○ ○	○ ○	○ ○
b. Has a member of the medical profession recommended hospitalization, surgery, or nursing home confinement that has not yet occurred?	○ ○	○ ○	○ ○	○ ○	○ ○
3. Within the last 5 years has any person proposed for coverage been diagnosed or treated by a member of the medical profession for internal cancer (except basal cell cancer)?	○ ○	○ ○	○ ○	○ ○	○ ○
4. Within the past 2 years has any person proposed for coverage been hospitalized or seen in an emergency room by a member of the medical profession for:					
a. Angioplasty, stent placement, heart surgery	○ ○	○ ○	○ ○	○ ○	○ ○
b. Angina (heart related chest pain), heart attack, hypertension, congestive heart failure, peripheral vascular disease (circulatory problems)	○ ○	○ ○	○ ○	○ ○	○ ○
c. Emphysema, chronic lung disease, asthma	○ ○	○ ○	○ ○	○ ○	○ ○
d. Cerebral vascular accident (CVA, stroke), cerebral vascular insufficiency, transient ischemic attack (TIA, ministroke)	○ ○	○ ○	○ ○	○ ○	○ ○
e. Type II diabetes	○ ○	○ ○	○ ○	○ ○	○ ○
f. Parkinson's Disease	○ ○	○ ○	○ ○	○ ○	○ ○
g. Crohn's Disease, ulcerative colitis	○ ○	○ ○	○ ○	○ ○	○ ○
h. Sickle cell anemia	○ ○	○ ○	○ ○	○ ○	○ ○
i. Transplants	○ ○	○ ○	○ ○	○ ○	○ ○

5. Does any person proposed for coverage have any other Hospital Indemnity 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.

6. 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

Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud.

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

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

Signed At _____
City

State

_____
Signature of Primary Insured/Owner
(Parent or Guardian if Child only coverage)

/ /
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

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) ____ / ____ / ____

CREDIT CARD INFORMATION

Card Holder 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:

Signature of Card Holder_____ Date (MM/DD/YYYY) ____ / ____ / ____

Name as it appears on the credit card statement (If different from 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) ____ / ____ / ____

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 HOSPITAL INDEMNITY POLICY FORM 90840 KS

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 Limitations 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, as defined in the Policy.

BENEFITS SUMMARY

Hospital Confinement Lump Sum Benefit. If a Covered Person is confined as an inpatient in a Hospital for the treatment of an Injury or Sickness, Kanawha will pay the Hospital Confinement Lump Sum Benefit Amount shown on the Policy Schedule. This benefit is subject to a maximum of one Hospital Confinement for each Covered Person each Calendar Year. Other maximums may apply as well.

Hospital Confinement Lump Sum Benefit Amount: [$_____]

Emergency Room Treatment Lump Sum Benefit. If a Covered Person requires and receives Emergency Room Care in a Hospital emergency room due to an Injury or Sickness, Kanawha will pay the Emergency Room Treatment Lump Sum Benefit Amount shown on the Policy Schedule. This benefit is subject to a maximum of two Hospital emergency room visits for each Covered Person each Calendar Year. Other maximums may apply as well.

Emergency Room Treatment Lump Sum Benefit Amount: [$_____]

Outpatient Surgery Lump Sum Benefit. If a Covered Person requires and undergoes an Outpatient Surgical Procedure due to an Injury or Sickness, Kanawha will pay the Outpatient Surgery Lump Sum Benefit Amount shown on the Policy Schedule. This benefit is subject to a maximum of two Outpatient Surgical Procedures for each Covered Person each Calendar Year. Other maximums may apply as well.

Outpatient Surgery Lump Sum Benefit Amount: [$_____]

BENEFITS ARE PAYABLE SUBJECT TO ALL OF THE TERMS OF THE POLICY.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY

GUARANTEED RENEWABLE. You can keep Your Policy until the Policy Anniversary date following the Primary Insured's 70th birthday. You must pay each Premium due before the end of the Grace Period. Your Premium can be changed if Kanawha changes the Premium on all policies in Your Premium class. Kanawha will give 60 days written notice before such Premium change starts. If You move, Your Premium may also change.

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.

Modal Premium: [$_____] [_____]

Payment Mode: [_____]

If You have Rider coverage under Your Policy, the above stated Premium includes [$_____.___] [_____] Policy Premium and [$XXX.XX] [Month] Rider 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.

OPTIONAL HOSPITAL CONFINEMENT DAILY BENEFIT RIDER (FORM 90841 KS)

Rider benefits are provided as outlined below for Covered Persons under Your Policy if You have Rider coverage. You have Rider coverage if You applied for it, if such coverage is shown on the Policy Schedule and the Rider was issued attached to Your Policy. If this Rider was not attached to Your Policy when You received it, then the Rider coverage is not available to Covered Persons under Your Policy. This is only a summary of Rider benefits. The terms contained in the Rider will control. **PLEASE READ YOUR RIDER.**

Hospital Confinement Daily Benefit. For each Full Day a Covered Person is confined as an inpatient in a Hospital, Kanawha will pay the Hospital Confinement Daily Benefit Amount shown on the Policy Schedule. Kanawha will pay this daily amount up to a total of 30 Full Days for any one period of Hospital Confinement.

Hospital Confinement Daily Benefit Amount: [$_____]

Intensive Care Unit Daily Benefit. For each Full Day of a Covered Person's Hospital Confinement that he or she is a patient in the Hospital's Intensive Care Unit (ICU), Kanawha will pay the Intensive Care Unit (ICU) Daily Benefit Amount shown on the Policy Schedule, up to a total of 30 Full Days for any one period of Hospital Confinement.

Intensive Care Unit (ICU) Daily Benefit Amount: [$_____]

For each Full Day that a Covered Person is in the ICU, only the ICU Daily Benefit will be paid. The Hospital Confinement Daily Benefit and the Intensive Care Unit Daily Benefit will not both be paid for the same Full Day.

EXCLUSIONS

No benefits are provided or paid under the Policy or Rider for any loss, expense, care or treatment due or related to:

- intentionally self-inflicted Injury;
- suicide or any attempted suicide, whether sane or insane;
- mental or emotional disorders without demonstrable organic disease;
- Injury or Sickness incurred as a result of engaging in an illegal occupation;
- voluntary ingestion, injection, inhalation or use of any drug, narcotic or sedative, unless prescribed by and taken in accordance with the directions of the prescribing Physician;

- voluntary ingestion, injection, inhalation, taking, absorbing or use of any poison, poisonous gas, fumes or any other substance that results in Injury or Sickness;
- being intoxicated as intoxication is defined by the laws of the state in which the incident occurred;
- alcoholism or drug addiction;
- war, whether declared or undeclared;
- cosmetic surgery;
- elective surgery not medically necessary, other than organ donation and complications related to organ donation;
- dental services or dental treatments unless necessitated by Injury;
- Injury or Sickness incurred as a result of being engaged as a paid athlete;
- participation in a riot, felony or insurrection;
- travel in, on or descending from any kind of aircraft, unless as a fare paying passenger on a commercial airline, passenger on a private airline charter or as a passenger on a privately owned and operated airplane that seats more than ten (10) passengers;
- sky diving;
- eye examinations, eye glasses, hearing aids or the fitting thereof;
- care or treatment received outside of the United States or its territories; or
- care or treatment of a Covered Person's newborn child, newly adopted child or child recently placed for adoption with a Covered Person (except if Hospital Confinement for such child is due to Injury or Sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities).

RECEIPT FOR OUTLINE OF COVERAGE FOR POLICY FORM 90840 KS

Signature of Applicant	**Date**
Signature of Licensed Resident Agent	**Date**

THIS PORTION RETAINED BY APPLICANT

RECEIPT FOR OUTLINE OF COVERAGE FOR POLICY FORM 90840 KS

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

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.