

Application For First Benefit Cancer Insurance

PLEASE TYPE OR PRINT

1. List each person to be insured:

Full Name (Include Maiden Name)	Social Security	Marital Status	Birth Date	Sex	Height	Weight
A. Proposed Insured:						
B. Spouse:						
C. Dependent:						
D. Dependent:						
E. Dependent:						
F. Dependent:						

2. Residence of proposed insured:

Address	City	State	Zip	Phone Number

Billing Address (Leave blank if same as above): _____

3. Has any person to be insured been diagnosed as having, or received treatment during the last two years for cancer of the skin? Yes No

If yes, name of person(s): _____

4. Has any person to be insured ever been diagnosed as having, or received treatment during the last ten years for Internal Cancer, Leukemia, Hodgkin's Disease, or Melanoma? Yes No

If yes, name of person(s): _____

5. Has any person to be insured been advised (by a member of the medical profession) to have any diagnostic tests related to cancer which have not been performed or for which you have not received results? Yes No

6. Has any person to be insured ever been diagnosed as having, or ever received treatment for Acquired Immune Deficiency Syndrome (AIDS) or ever tested positive for the Immunodeficiency Virus (HIV)? Yes No

If yes, name of person(s): _____

7. Is this Policy intended to replace any existing Policy in this or any other Company? Yes No

If yes, list Company name and Policy number: _____

8. Benefit selected: \$10,000 \$20,000 \$30,000 \$40,000 \$50,000

9. Type of Plan selected: Individual Single Parent Family

10. Premium Payment Mode: Annually Semi-Annually Quarterly Bank Draft/EFT—monthly

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Insured's Statement and Authorization To Release Medical Information

I hereby apply to United Security Life and Health Insurance Company for a policy to be issued in reliance on my written answers to the foregoing questions. The answers are, to the best of my knowledge and belief, true. I agree the policy shall not be effective unless it has actually been issued. I have received an Outline of Coverage for the policy applied for.

The undersigned Agent certifies that the Applicant has read, or had read to him, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

I authorize any insurance company, hospital, physician or other practitioner having any information available as to my diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, to disclose such information to the United Security Life and Health Insurance Company for the purpose of determining my eligibility for insurance and the eligibility for benefits under this policy. I understand that any information obtained will not be released to any person or organization except to reinsuring companies or other persons or organizations performing business or legal services in connection with this application, with a claim or as may be otherwise lawfully required. I agree that a photostat of this authorization is to be acceptable. This authorization will remain in effect for a period of 30 months from the date signed. I understand that I, or my authorized representative, may request a copy of this authorization.

I certify: (1) I have accurately recorded the information supplied by the Applicant; and (2) I have given an Outline of Coverage for the policy applied for to the Applicant.

Agent's Signature:

Agent Number:

Agent Address:

Agent Phone:

Amount Paid to Agent: \$_____ For First ____ Months Premium

Date: / /

I understand that no benefits are payable for a diagnosis of cancer in the first 30 days after the effective date of this policy. I also understand that no person covered by this policy is also covered by a Title XIX program, Medicaid or any other similar name. This does not apply to residents of Arizona.

Applicant's Signature:

Mail Policy To: Agent Insured

Applicant's Signature:

Save Time & Money With Electronic Payments

Pre-authorized Bank Check Plan or Electronic Transfer are the convenient ways to pay your premiums. Payments are always on time with no unintentional lapses of your valuable protection. You have no checks to make out, no postage stamps to bother with, no premium notices to return, and less cost in billing fees.

AUTHORIZATION TO HONOR CHECKS DRAWN BY UNITED SECURITY LIFE AND HEALTH INSURANCE COMPANY

As a convenience to me, I hereby request and authorize you to pay and charge my account (checks or electronic debits) drawn on my account by and payable to United Security Life and Health Insurance Company, provided there are sufficient funds in said account to pay the same on presentation.

I agree that your rights with respect to each such debit shall be the same as if it were a check drawn on you and signed personally by me. I further agree that if any such check or electronic debit be dishonored, whether with or without cause, and whether intentionally or inadvertently, you shall be under no liability whatsoever, even though such dishonor results in the forfeiture of insurance. This authorization is to remain in effect until revoked by me in writing, and until you actually receive such notice.

Name of Bank:

Address of Bank:

Name of Depositor:

Signature of Depositor:

Date: / /

**If Bank Check Plan Or Electronic Transfer
ATTACH VOIDED CHECK HERE
and Sign Authorization Above**