INSURED'S STATEMENT AND HIPAA COMPLIANT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby apply to United Security Life & Health Insurance Company for insurance. I represent the statements I have made herein are complete and true. I understand the following: (a) if any material information on this application is incorrect, this coverage may be voided; and, (b) if this application is declined and a certificate is not issued, United Security Life & Health Insurance Company's only obligation will be to return any premium paid; and, (c) that United Security Life & Health Insur ance Company will pay benefits for a loss due to a pre-existing condition provided the pre-existing condition was fully disclosed in the application and this coverage has not been excluded or limited by name or specific description; and (d) there is no insurance in force until a certificate indicating the effective date is received from United Security Life & Health Insurance Company and the initial premium, including the applicable fee, is paid in full.
By this form (or copy), I authorize any medical practitioner, physician, pharmacist, pharmacy-related facility, hospital, clinic, healthcare professional, medically-related facility, records custodian, insurance company, or the Medical Information Bureau, that has any records of me or any members of my family named in this application, of our health, to give United Security Life & Health Company, its reinsurers, affiliates, or business associates, any such information which shall include but not be limited to, Alcohol or Drug abuse treatment, mental health diagnosis and treatment, Pharmacy prescriptions, HIV testing and treatment, Sexually Transmitted Disease (STD) testing and treatment, Genetic testing, Sickle Cell testing and treatment, lab data, and diagnostic testing.

I understand the information obtained by use of this authorization will be used by the insurance company to determine eligibility for insurance. Any information obtained will not be released by the company to any person or organization except to reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business or legal service in connection with my application, claim, or as may otherwise lawfully require or as I may further authorize. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. This authorization shall be valid for two and one half years from the date shown below. I acknowledge receipt of the important notice regarding a consumer report disclosure of information to the Medical Information Bureau. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to United Security Life & Health Insurance Company, P.O. Box 388342, Bedford Park, Illinois 60638, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of my providers has relied on this authorization or to the extent that United Security Life & Health Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. A photographic copy of this authorization and acknowledgement shall be as valid as the original.

Upon request I, or my authorized representative, is entitled to receive a copy of this authorization form. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit of knowingly present false information in an Application for Insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Disclaimer – If premiums are paid from your employer's account, it is understood that: 1. United Security Life & Health Insurance Company assumes no responsibility for compliance with the Employee Retirement Income Security Act of 1974 (ERISA) and amendments thereto, nor does it maintain that the policy is designed or marketed to comply with the requirements contained therein. The Company is not acting as a sponsor as defined in ERISA. Any compliance under this Act that is applicable to the sponsor will be fulfilled by the employer, as his own legal counsel may determine. 2. The policy is not guaranteed issue and will be fully underwritten by the Company which may result in the exclusion from coverage of certain family members (if applicable) and health conditions. United Security Life & Health Insurance Company assumes no responsibility for collection of premiums and/or failure of your employer to remit them on a timely basis.

DATED AT /_____/ /_____/ /_____/ /_____/
City State Zip Date

/_____/ /_____/
Applicant's Signature Spouse's Signature (if to be covered)

/_____/ /_____/
Dependents Signature if over 18 Dependents Signature if over 18

AGENT INFORMATION /_____/ /_____/
Print Name Phone

/_____/ /_____/ /_____/
Agent's Signature Agent Number Agent E-mail

PAYMENT INFORMATION ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Bank Draft (Monthly) ☐ Credit Card ☐ Direct Bill

Credit Card Number /_____/ ☐ Visa ☐ Mastercard ☐ Discover **Exp. Date** /_____/

EFT AUTHORIZATION As a convenience to me, I hereby request and authorize you to pay and charge my account (check or electronic debit) drawn on my account by and payable to United Security Life & 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.

/_____/ /_____/
Bank Name **Bank Address**

/_____/ /_____/ /_____/
Printed Name of Depositor **Signature of Depositor** **Date**

Application for Critical Illness Insurance

UNITED SECURITY
LIFE AND HEALTH INSURANCE COMPANY

PLEASE TYPE OR PRINT

Benefit Amount: $ _____/ ($10,000 - $50,000 in $5,000 increments)

Type of Plan selected: ☐ Individual ☐ Single Parent ☐ Family

Plan: ☐ Basic ☐ Extended

Premium Amount: $ _____/ Non-Refundable Application Fee: $25*

A. List each person to be insured:

Name: First, MI, Last	Birthdate	Age	SSN	Sex	DL #	Marital Status	Height	Weight

B. Personal Information

Street City State Zip Code

Home Phone Number (_____) _____
Other Phone Number (_____) _____
E-mail Address _____

Mailing Address (Leave blank if same as above) _____

Billing Address (Leave blank if same as above) _____

List occupations and duties of each Proposed Insured:

Insured	Occupation	Duties
Primary		
Spouse		
Dependent		
Dependent		
Dependent		

C. Beneficiary Information

Applicants Age 18+	Primary Beneficiary	Relationship to Insured	Contingent Beneficiary	Relationship to Insured

D. Existing Coverage

Does any Proposed Insured have any other Critical Illness (lump sum diagnostic benefits) coverage in force or applied for? If YES, list company name and amount of coverage: _____

Is this Policy intended to replace an existing Policy with United Security Life and Health or any other Company? **(Y / N)**

E. Medical Questions

1. Has any Proposed Insured received any medical ADVICE or TREATMENT from a member of the medical profession, or taken any prescription MEDICINE within the past 5 years for:

- **a**. Angina, stroke, transient ischemic attack (TIA), heart attack, atrial fibrillation, congestive heart failure, coronary artery disease or a heart valve replacement? ..... **(Y / N)**
- **b**. Cirrhosis, hepatitis B or C, or other liver disorder? ..... **(Y / N)**
- **c**. Received or been recommended to receive an organ transplant? ..... **(Y / N)**
- **d**. Kidney failure, polycystic kidney disease or abnormal renal function? ..... **(Y / N)**
- **e**. Cancer (excluding non-melanoma skin cancer), melanoma, brain tumor, Hodgkin's disease, or leukemia?..... **(Y / N)**
- **f**. Alzheimer's disease, dementia, Parkinson's disease, Cystic Fibrosis, Amyotrophic Lateral Sclerosis (Lou Gehrig's disease), lupus, or muscular dystrophy? ..... **(Y / N)**
- **g**. Chronic Obstructive Lung/Pulmonary disease, Emphysema, or any other lung disease requiring the use of oxygen? ..... **(Y / N)**
- **h**. Manic depression, Bipolar Disorder, Alcoholism or Alcohol Abuse, Drug Addiction or Drug Abuse? ..... **(Y / N)**
- **i**. Down's Syndrome, Cerebral Palsy, paralysis or Multiple Sclerosis? ..... **(Y / N)**
- **j**. If applying for the Extended Plan or the Extended with Return of Premium Plan: Glaucoma, optic neuritis, macular degeneration, loss of hearing (requiring the use of hearing aid(s) or loss of speech?.. **(Y / N)**

2. Is any Proposed Insured an insulin dependent diabetic? ..... **(Y / N)**

3. Has any Proposed Insured been diagnosed by a member of the medical profession as having AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex) or tested positive for HIV (Human Immunodeficiency Virus)?... **(Y / N)**

4. Has any Proposed Insured received or been recommended to receive an organ transplant? ..... **(Y / N)**

5. Has any Proposed Insured been convicted of reckless or careless driving, and/or of driving under the influence of alcohol or drugs in the past 5 years? ..... **(Y / N)**

6. Does any Proposed Insured participate in any of the following occupations/avocations/activities: Aviation of any kind (pilot, student pilot, or crew member), Bungee Jumping, Extreme Sports, Motorized Vehicle Racing, Mountain/Rock Climbing, Parachuting, Parasailing, Rodeo Activities, SCUBA Diving, Skydiving, or other hazardous activity? ..... **(Y / N)**

7. Does any Proposed Insured have any surgery, hospitalization, diagnostic tests, and/or test results anticipated, scheduled, or pending, or been advised by a medical professional to undergo hospitalization or diagnostic tests and not done so? ..... **(Y / N)**

If Yes to questions 1 through 7, name the Proposed Insured: _____

If any of the above questions are answered "Yes", the Proposed Insured(s) is/are not eligible for coverage.

8. Is any Proposed Insured currently on Medicare or Medicaid? ..... **(Y / N)**

9. Will any Proposed Insured cancel or replace any existing major medical insurance coverage as a result of this application?.. **(Y / N)**

10. In the past five years has any Proposed Insureds been diagnosed or treated by a member of the medical profession for any disease or disorder of the endocrine system including non-insulin diabetes (treated with oral medication and/or by diet), thyroid or other glands? ..... **(Y / N)**

11. in the past five years, has any Proposed Insured been diagnosed or treated by any member of the medical profession for high blood pressure, heart murmur, elevated cholesterol, or any disease or disorder of the blood, heart or circulatory system? **(Y / N)**

12. In the past 12 months, has any Proposed Insured been diagnosed or treated by a member of the medical profession for any injury, disease, or disorder of the back, neck, spine, or joint(s)?..... **(Y / N)**

13. Within the past two years, has any proposed insured experienced chest pain, shortness of breath, palpitation, unintentional weight loss, dizziness, fatigue, or numbness? ..... **(Y / N)**

14. Have 2 or more of any Proposed Insured's parents, brothers or sisters been diagnosed with:

- **a**. heart disease, stroke, breast cancer, or any malignant growths while they were under the age of 60? ..... **(Y / N)**
- **b**. Colorectal cancer, Alzheimer's Disease, or Senile Dementia prior to age 75? ..... **(Y / N)**
- **c**. Any other type of cancer occurring in more than one relative prior to age 55? ..... **(Y / N)**

15. Has any Proposed Insured used any tobacco or nicotine product (including patches and/or gum) within the past twelve months? ..... **(Y / N)**

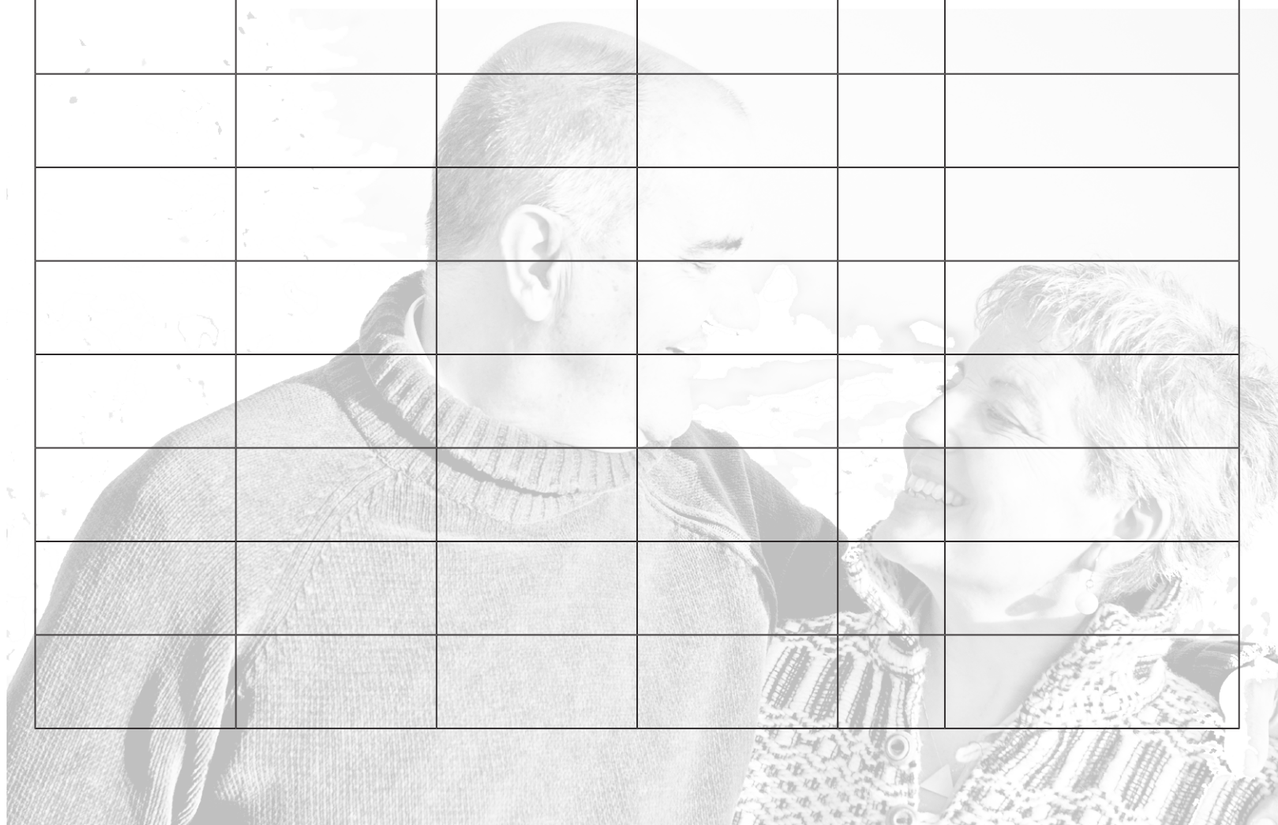
16. Within the past 5 years has any Proposed Insured had any medical advice or treatment from a member of the medical profession, been diagnosed with or taken any prescription medications for any other medical condition(s) not listed above? ..... **(Y / N)**

If "Yes" is answered to any question between 8 - 16, please explain in the spaces provided to the right.

F. Medical Information

Please provide complete information on all physicians.
(If you answered "Yes" to any question 8 through 16, provide details below)

Proposed Insured & Question Number	Health Condition	Treatment Received (Surgery, Rx, Therapy, etc.)	Medication	Dates	Physician and/or Clinic Name, Address & Phone



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