

# 1. Benefit Selection

|                                 |              |  |              |
|---------------------------------|--------------|--|--------------|
| <b>Requested Effective Date</b> |              | <b>Face Amount</b> (Choose from \$1,000 to \$25,000) |              |
| / /                             |              | \$   |              |
| <b>Primary Beneficiary</b>      |              | <b>Contingent Beneficiary</b>                        |              |
| Name                            | Relationship | Name   | Relationship |

# 2. Child Information

| Name of Proposed Insured (First, Middle Initial, Last Name) | Sex                                | Age  | Birth Date | State of Birth | Height  | Weight |
|---|------------------------------------|------|------------|----------------|---------|--------|
|   |                                    |      |            |                |         |        |
| SSN# of Proposed Insured                                    | Street Address of Proposed Insured | City | State      | Zip            | Phone # |        |
|   |                                    |      |            |                |         |        |

# 3. Replacing Life Insurance

|   |  |
|---|--|
| <b>Does the Applicant Currently Have Life Insurance In Force?</b>   | <b>Will First Step Replace Existing Policy?</b>          |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, Complete the Information Below:</i><br>Company Name: _____ Policy #: _____ Face Amount: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |

# 4. Medical Questions

**To the best of your knowledge and belief:**

Has the Proposed Insured been medically diagnosed, received medical care for, or had:

(a) a heart or circulatory system disease, birth defect, or mental or developmental disorder?.....  Yes  No

(b) any other chronic medical condition which has required care within the past 3 years?.....  Yes  No

(c) Acquired Immune Deficiency Syndrome (AIDS)?.....  Yes  No

Please list condition that caused yes answers to questions above.

# 5. Applicant (Owner) Information

**Applicant (Owner), if other than the Proposed Insured:** (Complete below and sign Signature Block at bottom of Application)

|                |                |   |  |
|----------------|----------------|---|--|
| <b>Name</b>    |                | <b>Relationship to Proposed Insured</b> |  |
|                |                |   |  |
| <b>Address</b> | <b>Phone #</b> | <b>Email</b>                            |  |
|                |                |   |  |

# 6.

## Insured's Statement And HIPAA Compliant Authorization To Release Medical Information

I hereby apply to United Security Life and Health Insurance Company ("USL&H") 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 Policy is not issued, USL&H's only obligation will be to return any premium paid; and, (c) there is no insurance in force until a Policy indicating the effective date is received from USL&H 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, medical or medically-related facility, records custodian, insurance company, or the Medical Information Bureau, that has any records of my health, to give USL&H, its reinsurers, affiliates, or business associates, any such information which shall include, but not be limited to, Alcohol or Drug abuse treatment, lab data, and diagnostic testing. I understand the information obtained by use of this authorization will be used by USL&H to determine eligibility for insurance. Any information obtained will not be released by USL&H 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 be otherwise lawfully required 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. (For residents of Arizona, this authorization is valid for 180 days for any HIV-related information. For residents of Nebraska, this authorization is valid for 24 months). I acknowledge receipt of the important notice regarding a consumer report and 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 USL&H, P.O. Box 388342, Chicago, 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 the extent that USL&H has a legal right to contest a claim under an insurance policy or to contest the policy itself within the two year Contestable Period. A photographic copy of this authorization and acknowledgment 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 or knowingly presents false information in an Application for Insurance may be guilty of a crime and may be subject to fines and confinement in prison.

### Signature of Applicant/Owner (if other than Proposed Insured)

X

Date

# 7.

## Agent's Statement

### Is insurance being applied for intended to replace any insurance now in force?

Yes  No If "YES", submit required Replacement Form.

I have truly and accurately recorded in this Application, the information supplied by applicant.

### Print Agent Name

### Licensed Agent Signature

### Agent No.

X

X

# 8.

## Premium Payment Mode (Include \$42 Annual Administrative Fee)

### Choose a Payment Method

Annually  Semi-Annually  Quarterly  PAC Monthly  Direct Monthly  Credit Card Monthly

### Visa/MasterCard/Discover #

### Expiration Date

### Name of Bank

### City

### State

### Routing Number

### Account Number

### Authorization Agreement for EFT

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 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.

### Signature

### Date