Kanawha Insurance Company

Application For Insurance

FRAUD: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is (in Georgia, Oregon and Nebraska "may be") a crime and subjects (in Georgia, Oregon and Nebraska "may subject") such person to criminal and civil penalties.

❑ **Check if replacing or changing existing coverage in this company. Policy Number** _____

PERSONS PROPOSED FOR INSURANCE

Last Name First Middle	Relationship	Birthdate	Sex	Height	Weight	Social Security No.
	Primary Insured	/ /				– –
	Spouse	/ /				
	Child	/ /				
	Child	/ /				
	Child	/ /				

Address	City	State	Zip / Home Telephone ( )
Secondary Addressee	City	State	Zip / Home Telephone ( )
Employer	Date Employed		Hours Worked/Wk
Occupation / Monthly Income $	Group Number CARE - M0000		Employee/Payroll Number
Payor or Owner if other than Primary Insured ❑ Payor ❑ Owner	Social Security No. – –		Relationship To Primary Insured
Beneficiary			Age / Relationship

FOR THE PAST 30 DAYS: Have all proposed Insureds been performing normal activities, and been actively at work full time at their regular occupation? ____Yes ____No. If "No", explain: _____

USED TOBACCO in the past 12 months? Primary Insured ____Yes ____No Spouse ____Yes ____No

WILL THIS POLICY REPLACE OR CHANGE ANY: Existing Life or Health Insurance in this or any other company? ____Yes ____No. If "Yes", complete replacement form where required.

INSURANCE PLANS

DISABILITY Primary Insured Only — Occ. Class ❑ 1 ❑ 2 — Injury / Sickness — Monthly Ben $_____ — Elim. Period _____ — Ben. Period _____ — Building Ben. Rider ❑ — 50% Ben. Reduction unless % selected here _____ — **Monthly Premium**

❑ _____
❑ _____

RIDERS

	AD&D	Emerg. Acc.	Hosp. Inj.	Hosp. Indem.	Outpat. Sick.	Spec. Inj.	1st Hosp. Conf.	_____	
Primary Ins.	$_____	$_____	$_____	$_____	$_____	❑	❑	$_____	
Spouse	$_____	$_____	$_____	$_____	$_____	❑	❑	$_____	
Children	$_____	$_____	$_____	$_____	$_____	❑	❑	$_____	$_____

HOSPITAL

	Base Policy	AD&D	Emerg. Acc.	Hosp. Inj.	ICU	Lump Sum	Outpat. Sick.
❑ 0/0 180 Primary Ins.	$_____	$_____	$_____	$_____	$_____	$_____	$_____
❑ 0/0 365 Spouse	$_____	$_____	$_____	$_____	$_____	$_____	$_____
❑ 0/3 365 Children	$_____	$_____	$_____	$_____	$_____	$_____	$_____

RIDERS

	Private Nurse	Surgical	Surgical+	Spec. Inj.	1st Hosp. Conf.	_____	_____	
Primary Ins.	$_____	$_____	$_____	❑	❑	$_____	$_____	
Spouse	$_____	$_____	$_____	❑	❑	$_____	$_____	
Children	$_____	$_____	$_____	❑	❑	$_____	$_____	$_____

CANCER Base Policy $_____ ❑ Primary Ins. ❑ Family

RIDERS

Surgical	Physician Att.	ICU	❑ Comp. Care First Occurrence	Disability Income $500 (Primary Ins. Only)	
$_____	$_____	$_____	❑ $500	❑ 6 Month Benefit	
Can. ICU	Chemo	Hospice	❑ $1000	❑ 1 Yr Benefit	$_____
$_____	$_____	$_____			

LUMP SUM CANCER ❑ Individual ❑ 1 Parent ❑ 2 Parent Max. issue in GA is $30,000
❑ $10,000 ❑ $20,000 ❑ $30,000 ❑ $40,000 ❑ $50,000 — $_____

LIFE ❑ _____ Amount $_____ ❑ Accidental Death Rider ❑ Waiver of Premium
❑ _____ _____ Units Family Rider _____ Units Children's Rider ❑ Other_____ — $_____

1.HAS ANY PROPOSED INSURED:

A) In the last 10 years been treated for or been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) and/or tested positive for HIV (Human Immunodeficiency Virus)? ____Yes _____No.

B) Consulted a Physician, received any medical treatment, or been hospitalized during the past 3 years? ____Yes ____No.

C) In the past 2 years had a driver's license suspended/revoked? ____Yes(License #_____ State _____) ____No.

2. IS ANY PROPOSED INSURED currently covered or eligible for Medicare? ____Yes ____No. If Yes, a "Guide to Health Insurance for People with Medicare" must be given to any Proposed Insured age 65 or over.

D1. FOR DISABILITY COVERAGE: List the amount of any other individual disability insurance currently applied for or in force for the primary insured $_____

C1. FOR CANCER COVERAGE: Has any proposed Insured in the last 10 years been treated for or been diagnosed as having: Cancer or any malignancy; Muscular Dystrophy; Poliomyelitis; Multiple Sclerosis; Encephalitis; Rabies; Tetanus; Malaria; Bubonic Plague; Smallpox; Tuberculosis; Osteomyelitis; Diphtheria; Scarlet Fever; Meningitis; Undulant Fever; Rocky Mountain Spotted Fever; Hansen's Disease; Addison's Disease; Sickle Cell Anemia; Tularemia; or Typhoid Fever? ____Yes ____No

L1. FOR LIFE COVERAGE, HAS ANY PROPOSED INSURED IN THE PAST 3 YEARS:

A). Used any illegal, restricted, or controlled substance or narcotics except by doctor's prescription or been advised to seek, or received treatment or counseling for alcohol or other drug use? ____Yes ____No

B). Had an application for insurance or reinstatement that was declined, postponed, rated up or modified? ____Yes ____No

C). Had or been treated for any disease of the lungs, blood, brain, heart, blood vessels, kidneys, pancreas, or liver or had or been treated for high blood pressure, paralysis, cancer, or tumor? ____Yes ____No

Details of "Yes" Answers in 1,D1,C1 or L1. Attach additional sheet if necessary.

Question No.	Name	Date	Type of Injury or Illness	Doctor/Hospital & Address	Fully Recovered?	Medication Taken

Insurance Information Practices: This notice describes the practices we, Kanawha Insurance Company, and your agent follow to manage your personal information. We will rely on the information you, the Primary Insured, provide in this application to decide if you and your dependents are insurable. We or your agent may telephone you to confirm information given in this application or to obtain additional information needed to process your application. Before asking other sources for information about you or your dependents, we will get your written authorization. Information you provide or authorize may be disclosed to third parties without authorization. You have the right to access and correct the information collected about you and your dependents except information that relates to a claim or civil or criminal proceeding. You will be given upon request our detailed Description of Information Practices by writing to us at P.O. Box 610, Lancaster, SC 29721-0610.

Agreement: I have read, or had read to me the completed application and agree that 1)all statements and answers about me and other proposed insureds are complete to the best of my knowledge and belief; 2) all statements and answers have been truly and accurately recorded; 3) acceptance of any policy issued on this application will constitute a ratification of any corrections and/or additions to the application by us in the section called "Home Office Corrections and/or Additions" for administrative purposes; 4) this application shall be part of any policy issued; 5) any false statement or misrepresentation herein may result in loss of coverage(s) subject to the Time Limit on Certain Defenses under the Policy; 6) any coverage(s) will be effective on the Policy Effective Date recorded on the Policy Specifications Page of the Policy, not the date the application is signed; 7) all exceptions, limitations, and pre-existing conditions pertaining to the coverage(s) applied for have been explained; 8)no person(s) to be covered for a specified disease is also covered by any Title XIX program (Medicaid or any similar name); and 9) the agent is not authorized to make or modify contracts, waive any Company rights or requirements, or waive any information the Company requests.

Home Office Corrections and/or Additions Only

I ☐ have ☐ have not received an Outline of Coverage. (For GA, MT, NV, OR, TX, WV)

X _____ Signed at _____ on _____/_____/20_____

Signature of Primary Insured (Parent if person to be insured is less than 15 years old) — City, State — Date

X _____ X _____

Signature of Owner (If other than Primary Insured) — **Spouse**

AGENT'S STATEMENT: I, the undersigned agent, also certify that to the best of my knowledge, replacement ❑ is ❑ is not involved at this time.

X _____ _____/_____/20_____ _____ _____ % _____

Signature of Agent — Date — Agent's No. — % Credit — State ID No.

1716 (07/10)

*Policy sold through Greater Insurance Service

Humana VIP Disability & Hospital Indemnity Policy Payment Form

Insured's Name: _____

Requested Effective Date:_____ (*all actual effective dates will be determined by underwriting)

Monthly Insurance Premium	**$** _____	Plans Enrolling in:	Monthly Premium
Monthly Administration Fee	**+ $ 4.00**	☐ Disability	_____
Monthly CARE Membership Fee	**+ $ 1.00**		
Total Monthly payment	**= $** _____	☐ Hospital Indemnity	_____

Please Select and Check one of the Following Payment Methods

☐ VISA Monthly ☐ MasterCard Monthly

**There is a 4% service fee for this option*

1. Please complete the following account information and submit with a check for the first month's premium made payable to Greater Insurance Service
2. Premium will be charged around the 20th of each month for the next month's premium

Account # ____ ____ ____ ____ - ____ ____ ____ ____ - ____ ____ ____ ____ - ____ ____ ____ ____

Expiration Date: ____/____/____

Name as it appears on the card: _____

Cardholders Signature: _____

☐ Personal Account Insurance Deduction (P.A.I.D.) Arranged by Greater Insurance Service Corp

Instructions for P.A.I. D.

1.-Please submit one month's premium made payable to Greater Insurance Service & voided check (no deposit slips)

2.-Premium will be deducted around the 15th of each month for the next month's premium

Please Select the Account Type for Withdrawal ☐ Checking Account ☐ Savings Account

WITHDRAWAL AUTHORIZATION

Name of Depositor _____

(Print name as shown on Financial Institution Records)

To Financial Institution _____

(Address of Institution or Branch where account is maintained)

TRANSMIT/ROUTING ABA#_____

ACCT. NO. _____

PRE-AUTHORIZED WITHDRAWAL PAYMENT METHOD

As a convenience to me, I hereby request and authorize Greater Insurance Service Corp. to pay and charge to my account, maintained at the above named financial institution, for the payment of premiums due on policies I currently have or may purchase and desire to include under the P.A.I.D. Agreement. The amounts will be drawn on my account by and payable to the order of Greater Insurance Service Corp. provided there are sufficient funds in said account to pay the same upon presentation. This authorization will remain in effect until revoked by me in writing and until Greater Insurance Service Corp. actually receives such notice. I agree that Greater Insurance Service Corp. shall be fully protected in honoring any withdrawals. I understand that if the withdrawal is presented and not honored for any reason and the amount due is not paid, Greater Insurance Service Corp. assumes no responsibility for a policy lapse or cancellation due to non-payment. This arrangement shall terminate immediately upon the closing of my account with you or upon receipt by you of notice of my bankruptcy. I agree that your treatment of my rights in respect to each such charge shall be the same as if they were signed personally by me. A customer has the right to stop payment of a debit entry by notification to Financial Institution prior to charging account. After account has been charged the customer has the right to have the amount of an erroneous entry immediately credited to their account by Financial Institution up to 15 days following the issuance of statement or 45 days after posting, whichever occurs first.

_____ _____

Date Signature of Depositor

Form: CARE APP 12-10