United National Life Insurance Company of America
1275 Milwaukee Ave. - Glenview - Illinois - 60025-1154 - 800-207-8050
Combined Application for Hospital Confinement (U9910) / Hospital Confinement & Home Care Indemnity (U0950)
First Diagnosis Cancer (U0430)

Section A: Applicant Information

[Applying For: (*please check one)* ☐ New Coverage ☐ Reinstatement ☐ Increase in Benefits

Primary Applicant

1. Last Name _____ First Name _____ _____ MI _____

Social Sec #_____-_____-_____ Age _____ Gender: M ☐ F ☐ Birth date _____/_____/_____

Spouse

2. Last Name _____ First Name _____ _____ MI _____

Social Sec #_____-_____-_____ Age _____ Gender: M ☐ F ☐ Birth date _____/_____/_____

Dependents

3. Last Name _____ First _____ MI __ Age ___ Birth date ___/___/___ Social Sec #_____-___-_____

4. Last Name _____ First _____ MI __ Age ___ Birth date ___/___/___ Social Sec #_____-___-_____

5. Last Name _____ First _____ MI __ Age ___ Birth date ___/___/___ Social Sec #_____-___-_____

6. Last Name _____ First _____ MI __ Age ___ Birth date ___/___/___ Social Sec #_____-___-_____

(For additional dependents, please attach a separate piece of paper, signed by the applicant, including the above information for each dependent.)

7. Street Address _____ City _____ _____ ST ____ Zip Code _____

8. Telephone (Day) _____ Applicant's E-mail Address_____

Section B: Coverage Selection and Premiums

☐ Hospital Confinement Indemnity (U9910)	☐ Hospital Confinement & Home Care Indemnity (U0950) **Secure Advantage**	☐ First Diagnosis Cancer (U0430) **Cancer Plus**
Coverage: (*check applicable)* ☐ Primary Applicant ☐ Spouse ☐ Dependent Children	**Coverage: (*check applicable)*** ☐ Primary Applicant ☐ Spouse	**Coverage: (*check applicable)*** ☐ Primary Applicant ☐ Family
Plan Daily Benefit: *(check one)* ☐ Plan A: $37.50 ☐ Plan D: $225 ☐ Plan B: $100 ☐ Plan E: $300 ☐ Plan C: $150 ☐ Plan F: $400	**Plan:** *(check one)* ☐ Plan A ☐ Plan C ☐ Plan B ☐ Plan D	**Scheduled Base Plan** (*check one*) ☐ Plan A ☐ Plan C ☐ Plan B ☐ Plan D
	Riders ☐ Dependent Children – Plan A Only	**Riders** ☐ Heart Attack and Stroke ☐ Return of Premium ☐ Lump Sum $_____ $1,000 - $10,000
Rider ☐ Dental and Vision (RU12DV) ☐ Primary: ☐ $400 ☐ $800 ☐ $1,200 ☐ Spouse: ☐ $400 ☐ $800 ☐ $1,200 ☐ Dependents 18+: ☐ $400 ☐ $800 ☐ $1,200	☐ Dental and Vision (RU12DV) ☐ Primary: ☐ $400 ☐ $800 ☐ $1,200 ☐ Spouse: ☐ $400 ☐ $800 ☐ $1,200 ☐ Dependents 18+: ☐ $400 ☐ $800 ☐ $1,200	☐ Dental and Vision (RU12DV) ☐ Primary: ☐ $400 ☐ $800 ☐ $1,200 ☐ Spouse: ☐ $400 ☐ $800 ☐ $1,200 ☐ Dependents 18+: ☐ $400 ☐ $800 ☐ $1,200

Check boxes below for dependents covered under the Dental and Vision Rider: (All dependents must apply for same level.)
☐ Dependent Line 3 ☐ Dependent Line 4 ☐ Dependent Line 5 ☐ Dependent Line 6

Modal Premium: **$**_____ +Policy Fee: **$**_____ = Premium Due: **$**_____	Modal Premium: **$**_____ +Policy Fee: **$**_____ = Premium Due: **$**_____	Modal Premium: **$**_____ +Policy Fee: **$**_____ = Premium Due: **$**_____

Premium Payment Modes: ☐ Monthly Bank Draft (.084) ☐ Quarterly (.265) ☐ Semi-Annual (.52) ☐ Annual
(If applying for more than one product, only one Policy Fee is required)

Total Premium Collected: $_____]

Section C: Medical / Underwriting Questions

Replacement question must be answered for ALL plans.

1a. Will the coverage(s) being applied for replace any existing hospital, medical, major medical, or hospital confinement indemnity insurance in this or any other company? ..... ☐Yes ☐ No

If yes, name of person this applies to _____ Company _____

If yes, submit appropriate replacement form – (if needed in your state).

[Hospital Confinement Indemnity (U9910)

Answer the following question if applying for the Hospital Confinement Indemnity (U9910)

1b. Does any person to be insured have any inforce or applied for hospital confinement indemnity insurance in this or any other company? ..... ☐Yes ☐ No

If yes, name of the person this applies to _____ Amount of Coverage _____]

[Secure Advantage - Hospital Confinement & Home Care Indemnity (U0950)

Answer the following questions if applying for the Secure Advantage Plan (U0950)

If the answer to any of the following questions is "Yes," that person does not qualify for this plan.

1c. Is any person to be insured currently in a hospital, nursing home or receiving home health care or disabled, receiving disability, applying for disability benefits or planning to apply for disability in the next 60 days? .....☐Yes ☐ No

2c. In the past 24 months, has any person to be insured been diagnosed by a member of the medical profession as having a heart attack or stroke or had heart surgery/bypass or angioplasty? ..... ☐Yes ☐ No

3c. In the past 24 months has any person to be insured been diagnosed or received treatment by a member of the medical profession for chronic obstructive lung disease, insulin dependent diabetes, drug or alcohol use, cancer (not skin cancer), congestive heart failure or chronic liver or kidney disease? ..... ☐Yes ☐ No

4c. In the past 12 months, has any person to be insured been advised by a member of the medical profession to have surgery but has not yet done so?..... ☐Yes ☐ No

5c. Has any person to be insured ever tested positive for or been diagnosed by a member of the medical profession as having Acquired Immune Deficiency syndrome (AIDS) or the HIV virus? ..... ☐Yes ☐ No

If yes, name of person this applies to _____

Primary Applicant's Beneficiary Name _____ Relationship _____]

[Cancer Plus - First Diagnosis Cancer (U0430)

Answer the following questions if applying for the Cancer Plus (U0430):

1d. In the past 10 years, has any person to be insured had, ever diagnosed as having, received medication for, or been treated by a medical practitioner for:

a. Internal cancer, Leukemia, Hodgkin's disease, malignant melanoma, or sarcoma? ..... ☐Yes ☐ No

b. Heart attack, heart bypass, angioplasty or stent placement, angina, stroke or Transient Ischemic Attack (TIA)?..... ☐Yes ☐ No

2d. In the past 10 years has any person applying for coverage been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency syndrome (AIDS) or the HIV virus? ..... ☐Yes ☐ No

3d. In the past 24 months, has any person to be insured been advised to seek treatment or medical advice from a medical practitioner for any of the conditions listed in Questions 1d or 2d, but has not done so?..... ☐Yes ☐ No

If yes, name of person this applies to _____]

[Dental and Vision (RU12DV)

Answer the following question if applying for the Dental and Vision (RU12DV):

1e. Does any person to be insured currently wear prescription eyewear, glasses or contacts? ..... ☐Yes ☐ No

If yes, name of person this applies to _____]

Section D: Authorization / Agreement

ALL STATEMENTS MADE IN THIS APPLICATION ARE FULL, COMPLETE AND TRUE, TO THE BEST OF MY (OUR) KNOWLEDGE AND BELIEF. I (WE) UNDERSTAND THAT THE STATEMENTS FORM THE BASIS UPON WHICH INSURANCE WILL BE MADE EFFECTIVE. I (WE) UNDERSTAND THAT OMISSIONS, MISREPRESENTATIONS OR MISSTATEMENTS COULD RESULT IN DENIAL OF AN OTHERWISE VALID CLAIM AND/OR RESCISSION, VOIDING, OR REFORMATION OF INSURANCE.

I (We) understand that insurance applied for will not become effective until: a) approved and issued by United National Life Insurance Company of America (herein referred to as the "Company"); b) I (We) have been furnished written notice of the effective date; and c) I (We) have paid the premium in full. I (We) understand that any changes in my (our) health conditions, if applicable, from the date of this application until insurance becomes effective, may result in the declination of my (our) coverage. No agent or other representative of the Company has required, permitted, or encouraged me (us) to answer any question inaccurately or has waived any conditions of this application. I (We) have received a copy of the Pre-Notice which describes how information is obtained and used by the Company. If this application is completed electronically, I (We) understand the Pre-Notice will be delivered electronically or with the policy. If the application is completed over the phone the Pre-Notice will be delivered with the policy.

AUTHORIZATION: I (We) authorize United National Life Insurance Company of America (herein referred to as the "Company"), insurance support organizations, authorized representatives, and any reinsurers, to obtain information as to the diagnosis, treatment, or prognosis of my (our) physical condition, other coverage and any other information needed to underwrite my (our) application for insurance such as criminal or motor vehicle records. Upon presentation of this Authorization, or a photocopy of it, the Company may obtain, without restriction (except psychotherapy notes), such information or records from any doctor, health professional, hospital, clinic, Veterans Administration, insurance company, pharmacy benefit managers, pharmacies, pharmacy-related facilities or other person or organization which has such information including any information provided to any affiliate insurance company on previous applications and any information provided to our health division for underwriting or claim servicing purposes. The Company, or its reinsurers, may also obtain such information from MIB, Inc. I (We) authorize the Company, or its reinsurers, to make a brief report of my (our) personal health information to MIB, Inc. This Authorization includes all information about drugs, alcoholism, and mental illness. I (We) understand and agree that the Company or its representatives may conduct a phone interview or face-to-face assessment as part of the underwriting process. Although federal regulations require that the Company inform Me (Us) of the potential that information disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected if such information is disclosed to a person or entity not covered by the federal privacy regulation, all such information received by the Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. I (We) agree that this Authorization will be valid for 24 months from the date signed, and know that I (We) or my (our) authorized representative may have a photocopy of it.

I (We) have received an Outline of Coverage. If this application is completed electronically, I (we) understand the Outline of Coverage will be delivered electronically or with the policy. If the application is completed over the phone the Outline of Coverage will be delivered with the policy.

I (We) understand that I (We) have the right to revoke this Authorization, in writing, at any time by sending written notification to my (our) agent or to the Company at the above address. I (We) understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or, so long as the Company has a legal right to contest a claim under the coverage or the coverage itself. Revocation requests should be sent in writing to my (our) agent or to the attention of the Underwriting Manager.

I (We) understand once information is disclosed pursuant to this Authorization, such information will continue to be protected by UNL in accordance with federal or state law. I (We) also understand that my (our) application for insurance can be declined if I (We) choose not to sign this Authorization.

Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

I (We) attest that I (We) have the minimum essential coverage defined in 26 U.S.C. 5000A(f) and required by the Patient Protection & Affordable Care Act.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Signed at _____

Date City and State

_____

Signature of Applicant Spouse/Domestic Partner Signature (if applicable)

AGENT'STATEMENT

I am not aware of any additional information which may have a bearing on the insurability of anyone proposed for insurance on this application and any supplement to it. I have advised the applicant not to withhold any information relative to this application and its questions. I have advised the applicant to review the application for completeness and accuracy and that no coverage is in effect until the applicant is notified in writing by United National Life Insurance Company of America. I certify that I asked all the questions and truthfully and accurately recorded the answers contained herein (except if application is completed electronically or over the phone). To the best of my knowledge and belief, the insurance applied for: □ is or is likely or □ is not or is not likely to replace or change any existing policy(ies) or contract(s).

Agent's Name (Printed)	Agent Code	Date Signed

Agent's signature	Agent's E-mail Address

Mail Policy to ☐ **Agent** ☐ **Insured**

MONTHLY PRE-AUTHORIZED PREMIUM PAYMENT PLAN

Authorization to Honor Withdrawals to be drawn by United National Life Insurance Company of America.

TO _____

Name of my Bank | My Bank's Address | City | State | Zip Code

As a convenience to me, I request and authorize you to charge the account shown below for premiums drawn by and payable to the order of United National Life Insurance Company of America, Glenview, Illinois, provided there are sufficient funds in my account to pay the same upon presentation.

Account #: _____ Bank Routing #: _____

Account Type: ❑ Checking Account *(Attach a Voided "Sample" check)* ❑ Savings Account *(Attach a Voided "Sample" check) if applicable, or a Deposit slip*

I agree that my rights in respect to each payment shall be the same as if it were drawn by me and signed personally by me. This authority is to remain in effect until revoked by me in writing and until you receive notice for which you agree you will be fully protected in honoring such requests. I further agree that if any such payment is not honored, whether with or without cause and whether intentionally, or inadvertently, you shall be under no liability at all although such action could result in the forfeiture of insurance.

_____ _____

Printed name of insured if different from premium payer | Premium payer's signature, as it appears on bank records

AGENT NOTE: Please tear off this page and leave it with the Applicant.

United National Life Insurance Company of America

NOTICE TO APPLICANT – PARTS 1 AND 2

Part 1: Fair Credit Reporting Act and Privacy Act Pre-Notification

The application you completed for insurance with us, in most cases, gives us all the information we need. In certain cases, we may need more information.

If we need more information, we may get it by talking to other persons you know including, but not limited to, your agent or other insurance companies you have applied to. We may ask an independent "consumer reporting agency" to help us verify facts or get additional facts.

We may collect information covering your health, job and financial situation, as well as your character, general reputation and mode of living. We will not collect information relating to your sexual orientation.

The personal information we obtain about you is treated as confidential and will not be disclosed to other persons or organizations without your written authorization except to the extent necessary, as permitted by law, for the conduct of our business. But any information collected by a "consumer reporting agency" may be shared by the agency with others who use such information, but only to the extent which the Fair Credit Reporting Act permits.

You have a right of access, and right of correction, concerning recorded personal information obtained in our file. In order to exercise these rights, you must contact us in writing requesting access or correction. You have no access right to privileged information. If we used a "consumer reporting agency" you have the right to: (1) ask to talk with them and (2) ask them about their report. You may write us for the name and address of the agency. This paragraph is not intended as a complete description of your right of access and correction. If you would like a more complete description of our Insurance Information and Privacy Protection Practices, please write: United National Life Insurance Company of America, P.O. Box 1154, Glenview, IL 60025-1154.

Part 2: Notification Regarding MIB, Inc.

Information regarding your insurability will be treated as confidential. United National Life Insurance Company of America or its reinsurers may, however, make a brief report thereon to the MIB, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, Inc., upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the MIB Inc.'s file, you may contact them and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address to MIB Inc.'s office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number (866) 692-6901, e-mail address infoline@mib.com. United National Life Insurance Company of America or its reinsurers may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may also apply for life or health insurance, or to whom a claim for benefits may be submitted.

DESCRIPTION OF INFORMATION PRACTICES

The description of Information Practices is being provided by United National Life Insurance Company of America in accordance with the requirements of the Insurance and Privacy Protection law in effect (if required) in your state of residence. Your application, in most instances, gives us all needed information. However, in some cases, we need to obtain more information by contacting other sources. This information, as well as other personal or privilege information collected, may in certain circumstances be disclosed to third parties without your authorization, but only to the extent permitted by law. You have the right of access and correct recorded personal information in our file (but not privileged information) by writing to us. This notice is not intended to be a complete description of your rights. For a complete description of our information practices, please write:

United National Life Insurance Company of America
P.O. Box 1154
Glenview, Illinois 60025-1154

RECEIPT

DATE _____

Received of _____ the sum of $ _____ and an application for insurance to United National Life Insurance Company of America. If for any reason the application is declined this payment will be refunded. No liability is created or assumed by the Company, except for refund of this payment, until the insurance applied for has been issued.

Agent's Signature _____

If you do not receive your policy/certificate within 60 days from the date of your application, please write to:
United National Life Insurance Company of America, P.O. Box 1154, Glenview, Illinois 60025-1154

MAKE CHECK PAYABLE TO: UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA

UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA
P. O. Box 1154, Glenview, Illinois 60025
1-847-803-5252

HIPAA AUTHORIZATION

This Authorization was prepared by United National Life Insurance Company of America for purposes of obtaining information necessary to underwrite my (our application for insurance.

By signing this form, I (we) authorize United National Life Insurance Company of America (herein referred to as the "Company"), insurance support organizations, authorized representatives, and any reinsurers, to obtain information as to the diagnosis, treatment, or prognosis of my (our) physical condition, other coverage and any other information needed to underwrite my (our) application for insurance such as criminal or motor vehicle records. Upon presentation of this Authorization, or a photocopy of it, the Company may obtain, without restriction (except psychotherapy notes), such information or records from any doctor, health professional, hospital, clinic, Veterans Administration, insurance company or other person or organization which has such information including any information provided to any affiliate insurance company on previous applications and any information provided to our health division for underwriting or claim servicing purposes. The Company and its reinsurers may also obtain such information from the Medical Information Bureau. This Authorization includes all information about drugs, alcoholism, and mental illness. I (we) understand and agree that the Company or its representatives may conduct a phone interview or face-to-face assessment as part of the underwriting process. I (we) agree that this Authorization will be valid for 24 months from the date signed, and know that I (we) or my (our) authorized representative may have a photocopy of it. If this Authorization is for someone other than myself, that individual and my authority to act on their behalf is explained below.

I (we) understand that I (we) have the right to revoke this Authorization, in writing, at any time by sending written notification to my (our) agent or to the Company at the above address. I (we) understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or, so long as UNL has a legal right to contest a claim under the coverage or the coverage itself. Revocation requests should be sent in writing to my (our) agent or to the attention of the Underwriting Manager.

I (we) understand once information is disclosed pursuant to this Authorization, such information will continue to be protected by UNL in accordance with federal or state law. I (we) understand that my (our) application for insurance can be declined if I (we) choose not to sign this Authorization. I (we) understand that if this form is signed electronically, such signature operates as my original. This electronic signature fully complies with the Federal Electronic Signature Statute, Title 15, U.S.C. Chap. 96, Sec. 7001, et seq. and is therefore fully legal as my original signature.

_____
(Print Please) Name of Applicant

_____
Signature of Applicant and Date

_____
(Please Print) Name of Authorized Representative, or Next of Kin

_____
Relationship of Authorized Representative or Next of Kin to Patient

_____
Signature of Authorized Representative or Next of Kin and Date