PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY

P.O. Box 4884 • Houston, TX • 77210-4884

Application for: Enhanced 24 Hour Accident Expense Insurance Policy

PART I – GENERAL INFORMATION

1. PERSONS TO BE COVERED

Name (Please PRINT Full Name)	Relationship	Sex	Date of Birth	Age	Height Ft. In.	Weight Lbs.	Social Security Number
1.							
2.							
3.							
4.							
5.							

2. APPLICANT'S HOME ADDRESS

Address: _____

City: _____ State:_____ Zip: _____

Home Phone: (_____) _____

Work Phone: (_____) _____

E-mail Address: _____

3. PREMIUM PAYOR ADDRESS (If different than Applicant)

Premium Payor Name: _____

Address: _____

City:_____ State:_____ Zip: _____

Phone: (_____) _____

4. EMPLOYMENT INFORMATION (All adult applicants)

Employer's Name: _____

Occupation/Duties: _____

Spouse's Employer's Name (if applying): _____

Spouse's Occupation/Duties: _____

5. BENEFIT INFORMATION

Benefit Amount: ☐ 1 Unit ☐ 2 Units

Plan Type: ☐ Individual ☐ Individual & Spouse

☐ Single Parent ☐ Family ☐ Child Only (per child)

Billing Method: ☐ Monthly Bank Draft ☐ Direct Bill ☐ List Bill

Billing Mode: ☐ Quarterly ☐ Semi-Annual ☐ Annual

6. OPTIONAL RIDER

Accident Disability Income ☐ Type 1 ☐ Type 2

Benefit Rider ☐ 1 Unit ☐ 2 Units

☐ 12 Months ☐ 24 Months

7. BENEFICIARY

Name: _____

Relationship: _____

_____

PART II – REPRESENTATION & QUESTIONS OF THE APPLICANT

	YES	NO
1. In the past 12 months, has any person to be insured engaged in racing, parachuting, rodeo riding, motorcycling, mountain climbing or scuba diving?	☐	☐
2. Is any person to be insured currently under treatment or has any person to be insured been under treatment for excessive drug or alcohol abuse in the past 3 years?	☐	☐
3. Are all persons to be insured ages 19 to 25 years old enrolled as a full time student in an accredited school of college?	☐	☐
4. Will the insurance applied for replace or change any existing insurance?	☐	☐
If YES, give name of Company and type of insurance:_____		
5. Does every proposed insured have other Health Coverage (with exception of Specified Disease Insurance) in force, that will not be replaced by the issuance of this policy? ……..	☐	☐
If the answer is NO, then that proposed insured is not eligible for issuance of this policy.		

HOME OFFICE USE ONLY: Agent #_____ Policy #_____ Eff. Date_____ Initial Premium_____

If Bank Draft Authorization, ATTACH VOIDED CHECK HERE and sign authorization at right.

AUTHORIZATION TO MY BANK

As a convenience to me, I hereby request and authorize you to pay and charge my account, checks drawn on my account by and payable to the order of the Philadelphia American Life Insurance Company, Houston, Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such checks 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. A photocopy of my signature should be honored as if it were original.

_____ X_____

Date Signature (as it appears on bank records)

AUTHORIZATION FOR PAYROLL DEDUCTION

Employee_____ I hereby authorize_____

Name Name of Employer

to deduct from my salary and pay to Philadelphia American Life Insurance Company, Houston, Texas, the monthly deposits as set forth below. Beginning with the month of_____, $_____ each month.

_____ _____

Date Signature of Employee

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

A. I hereby authorize and request any physician, hospital, dentist, pharmacy, individual, employer, insurance company, law enforcement agency, governmental agency or other entity to permit bearer or representative of Philadelphia American Life Insurance Company to view, copy, be furnished a copy or be given details of all record information in connection with any past or present illnesses, financial records, employment records and/or police records. This authorization is to include, but is not limited to information pertaining to diagnosis, care or treatment for psychiatric disorder, drug and alcohol abuse, treatment or prescriptions, testing and/or treatment of HIV (AIDS virus) and/or sexually transmitted diseases. The results of an HIV-related test shall be confidential and we cannot release or disclose this information except in the circumstances permitted by 28 TAC § 21.704.

B. Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, my employer, the Medical Information Bureau, Inc. ("MIB") or consumer reporting agency or insurance company who possesses information of care, treatment or advice of me, my family, or our health may furnish such information to Philadelphia American Life Insurance Company or it's representative or it's reinsurers upon presenting this authorization or a photocopy.

C. Philadelphia American Life Insurance Company or its reinsurers may make a brief report available regarding me or my dependents to other companies to whom I have applied or may apply.

D. This authorization will be valid from the date signed for a period of two and one half years.

E. I authorize Philadelphia American Life Insurance Company to obtain an investigative consumer report on me.

Dated: _____ Dated at: _____

Signed **X** _____ Signed **X**_____

Signature of Proposed Insured Signature of Spouse

APPLICANT'S STATEMENT

1. I hereby apply to Philadelphia American Life Insurance Company for a policy to be issued in reliance on my written answers to the foregoing questions. The answers are true to the best of my knowledge and belief. 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.

2. 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 a crime and subjects such person to criminal and civil penalties.

3. I understand that if the Accident Disability Income Benefit Rider is elected, the maximum benefit per month will not exceed 60% of my gross monthly income.

Dated at_____ on_____ 20_____.

City, State & Zip Month & Day

Signature of Applicant:_____ Signature of Spouse:_____

AGENT'S STATEMENT

I Certify: 1) That any information recorded by me is true and correct to the best of my knowledge and belief. 2) I have given an outline of coverage for the policy applied for to the Applicant. 3) This (does) (does not) replace other insurance.

Dated_____ on _____ 20_____.

City, State & Zip Month & Day

_____

Agent Name (Print) Agent Signature Agent No.