PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®

P.O. BOX 4884, HOUSTON, TX. 77210-4884

APPLICATION

SUPPLEMENTAL HOSPITAL, MEDICAL AND SURGICAL EXPENSE POLICY (Form H-0230.PA)

Maximum Annual Benefit (total calendar year per person): ○ $2,000 ○ $3,000 ○ $4,000 ○ $5,000 ○ $6,000 ○ $7,000 ○ $8,000 ○ $9,000 ○ $10,000

Inpatient Deductible: ○ $0 ○ $250 ○ $500 ○ $1,000

Plan Type: ○ Individual ○ Individual and Spouse ○ Individual and Child(ren) ○ Family

ACCIDENT EXPENSE POLICY (Form H-0089.PA)

Accident: ○ 1 Unit ○ 2 Units

Plan Type: ○ Individual ○ Individual and Spouse ○ Individual and Child(ren) ○ Family ○ Child Only – how many? _____

Accident Expense Optional Benefits:

Disability Income Benefit Rider: ○ Occ.Type 1 ○ Occ. Type 2

Number of Units: ○ 1 Unit ○ 2 Unit

Benefit Period: ○ 12 Months ○ 24 Months

REQUESTED EFFECTIVE DATE: _____

○ New Business ○ Adding Dependent
○ Adding Spouse ○ Reinstatement

If Addition or Reinstatement List Current Policy Number:

_____

PAYMENT MODE: ○ Monthly ○ Quarterly ○ Semi-Annual ○ Annual

PAYMENT TYPE: ○ Monthly Bank Draft ○ Direct Bill ○ List Bill

PRINT APPLICANT'S NAMES (LAST, FIRST, MI, MAIDEN)	SOCIAL SECURITY	SEX	RELATION TO APPL.	DATE OF BIRTH	FTS Y/N	AGE	BIRTH STATE	HT.	WT.
1.									
2.			SPOUSE						
3.			DEP. 1						
4.			DEP. 2						
5.			DEP. 3						
6.			DEP. 4						
7.			DEP. 5						
8.			DEP. 6						

APPLICANT'S ADDRESS (Actual Address. We cannot use a P.O. Box)	CITY	STATE	ZIP	COUNTY
PREMIUM PAYOR ADDRESS (If different than Applicant's Address)	CITY	STATE	ZIP	COUNTY
BUSINESS NAME AND ADDRESS	CITY	STATE	ZIP	
HOME PHONE	BUSINESS PHONE	EMAIL		

DESCRIBE THE OCCUPATION AND SPECIFIC DUTIES FOR EACH ADULT APPLICANT:

APPLICANT: _____

SPOUSE: _____

SUPPLEMENTAL HOSPITAL, MEDICAL AND SURGICAL EXPENSE INSURANCE PREMIUM:	
ACCIDENT EXPENSE INSURANCE PREMIUM:	
ACCIDENT DISABILITY RIDER PREMIUM:	
APPLICATION FEE (non-refundable)	
TOTAL PAYMENT DUE:	

SUPPLEMENTAL HOSPITAL, MEDICAL AND SURGICAL EXPENSE INSURANCE

	Applicant YES/NO	Spouse YES/NO	Child 1 YES/NO	Child 2 YES/NO	Child 3 YES/NO	Child 4 YES/NO	Child 5 YES/NO	Child 6 YES/NO
1. Does each proposed Applicant have a Major Medical Policy or other comprehensive health coverage in force (or pending application)? Please list below: _____ Company _____ _____ Policy Number Effective Date	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
IF THE ANSWER TO QUESTIONS 2-7 IS "YES" THEN THAT APPLICANT IS NOT ELIGIBLE FOR SUPPLEMENTAL EXPENSE COVERAGE.								
2. During the past (3) months, except for minor illness of (1) week or less or pregnancy, has any illness or health related problem prohibited any proposed Applicant from working full time at his/her regular occupation or performing the normal activities of a person of the same age?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
3. Within the past 2 years, has any Applicant been diagnosed with or received treatment by a physician, tested positive or taken medication for any of the following conditions: Liver cirrhosis, Hepatitis B or C, insulin-diabetes and/or neuropathy, ulcerative colitis or Crohn's, Down's syndrome, Rheumatoid Arthritis, ALS (Lou Gehrig's Disease), Parkinson's, cystic fibrosis, cerebral palsy, sickle cell or aplastic anemia, transplant recipient, multiple sclerosis, muscular dystrophy, lupus, COPD, emphysema, suicide attempt, Stroke or TIA, paraplegia or quadriplegia, kidney or renal failure?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
4. Within the past 10 years has any Applicant tested positive or been diagnosed with or treated by a physician for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
5. Within the past 2 years has any Applicant been diagnosed with, taken medication or received treatment by a physician for a heart attack, had a bypass or stent, coronary artery disease, or been advised to have any diagnostic tests relating to the heart or circulatory system which have not been completed or for which results have not been received?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
6. Within the past 5 years has any Applicant been diagnosed with, taken medication or received treatment by a physician for internal cancer, leukemia, malignant melanoma or any other malignancy or been advised to have any diagnostic tests relating to cancer which have not been completed or for which results have not been received?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
7. Within the past 4 years has any Applicant used illegal drugs, been diagnosed with or received any medical treatment, taken medication for or been advised by a physician to have a medical test for alcohol or drug abuse?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
8. Within the past 24 months has any Applicant used any form of tobacco (including cigars, pipe or chewing tobacco)?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○

ACCIDENT EXPENSE INSURANCE

	Applicant YES/NO	Spouse YES/NO	Child 1 YES/NO	Child 2 YES/NO	Child 3 YES/NO	Child 4 YES/NO	Child 5 YES/NO	Child 6 YES/NO
IF AN ANSWER TO QUESTION 9 OR 10 IS "YES" THEN THAT APPLICANT IS NOT ELIGIBLE FOR COVERAGE.								
9. Within the past 12 months has any Applicant engaged in or had intentions to engage in any hazardous sports or activities including motorcycle or automobile racing, parachuting, rodeo riding, mountain climbing or scuba diving to depths greater than 60 feet (18 meters)?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
10. Within the past 3 years has any Applicant been under treatment for excessive drug or alcohol abuse?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○

STATEMENT OF OTHER INSURANCE AND BENEFICIARY FOR BOTH SUPPLEMENTAL AND ACCIDENT EXPENSE INSURANCE

11. Will the insurance applied for replace or change any existing insurance? If YES, give name of Company and type of insurance: _____	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
12. Is there any other health, accident or disability insurance in force on the proposed insured? If YES, give name of Company and type of insurance: _____	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○

13. List both Primary and Secondary Beneficiary

Primary: _____ Relationship: _____

Secondary: _____ Relationship: _____

FAMILY DOCTOR OR DOCTOR OF EACH APPLICANT WHO HAS CURRENT AND COMPLETE MEDICAL RECORDS

APPLICANT #1'S DOCTOR NAME:		PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP
SPOUSE'S DOCTOR NAME:		PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP
CHILDREN'S DOCTOR NAME:		PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP

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 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

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

If you intend to lapse or otherwise terminate existing insurance and replace it with a new plan from Philadelphia American Life Insurance Company, you should be aware of and seriously consider certain factors that may affect your coverage under the new plan.

1. Health conditions that you now have may not be immediately or fully covered under the new plan. This could result in a claim for benefits being denied, reduced, or delayed under the new plan, whereas a similar claim might have been payable under your present plan.
2. If after due consideration, you still wish to terminate your present insurance and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information or correct information regarding the tobacco use of any applicant may cause the company to deny a future claim and to void your coverage as though it has never been in force. After you have completed the application and before you sign it, reread it carefully. Be certain that all information has been properly recorded.
3. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of or addition to your present plan. You should be certain that you understand all the relevant factors involved in replacing or adding to your present coverage.
4. Finally, we recommend that you not terminate your present plan until you are certain that your application for the new plan has been accepted by Philadelphia American Life Insurance Company.

APPLICANT'S STATEMENT AND AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I hereby apply to Philadelphia American Life Insurance Company for coverage under a Policy to be issued in reliance upon the written answers to the questions in this Application which I have answered to the best of my knowledge and belief. I understand and agree that (1) the coverage shall not take effect unless the Application has been accepted and approved in writing by the Company and until the Effective Date of my coverage under the Policy and (2) my coverage will not become effective until all necessary underwriting information has been received and reviewed by the Home Office and that the requested Effective Date may be delayed if the Home Office requires additional medical information to process my Application and (3) the agent does not have the authority to waive a complete answer to any question in the Application, pass on insurability, make or alter any part of the contract, or waive any of the Company's other rights or requirements. I understand and agree that the falsity of any answer or statement in this Application may bar the right to recover under the Policy if such answer materially affects the acceptance of the risk or hazard assumed by the Company. The Company may rely upon this Application and all of the information contained herein.

I hereby authorize and request any physician, hospital, dentist, pharmacy, pharmacy benefit manager, 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. Health information obtained will not be re-disclosed without your authorization unless permitted by law, in which case it may not be protected under federal privacy rules. The results of an HIV-related test shall be confidential and we cannot release or disclose this information except in certain circumstances permitted by law. Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, my employer 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. 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. I understand that I may revoke this authorization at any time by writing to Philadelphia American Life Insurance Company and that I or my representative is entitled to receive a copy of this authorization form upon request. This authorization shall remain in effect for twenty four (24) months from the date this authorization is signed.

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. I acknowledge receipt of the Outline of Coverage and have read the Notice to Applicant Regarding Replacement of Accident and Sickness Insurance if this is a replacement.

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.

Dated at_____ on_____ 20_____.
City, State & Zip Month & Day Year

Signature of Applicant #1_____ Signature of Spouse:_____

AGENT USE ONLY

1. Will this coverage applied for replace or effect a change of any coverage with this or any other company? Please Explain: ○ YES ○ NO

_____

2. Did you personally meet with each Applicant? (If No, explain) ○ YES ○ NO

_____

3. I have truly and accurately recorded the information as herein supplied by the Applicant #1 for all family members. ○ YES ○ NO

4. I have left or made available an Outline of Coverage. ○ YES ○ NO

5. Mail Policy to: ○ AGENT ○ INSURED

AGENT NAME (Please print first and last name)	ADDRESS	CITY	STATE	ZIP
SIGNATURE OF AGENT ×_____	AGENT NUMBER	MONTH	DAY	YEAR

SPLIT AGENT LAST NAME	SPLIT AGENT NUMBER	SPLIT AGENT %
1.		
2.		
3.		

Agent Notes