PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY

Application for Hospital Indemnity Insurance

Hospital Indemnity Insurance Policy: Form H-0300

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY • P.O. BOX 4884, HOUSTON, TX 77210-4884 • 281-368-7200 • 1-877-368-4692

Coverage Selection

Hospital Indemnity Insurance	Requested Effective Date: _____
Plan Choice: ❒ Basic Plan ❒ Select Plan ❒ Premier Plan	$ _____
❒ Supplemental Insurance Rider for Critical Illness (H-0300.CI.RD)	$ _____
❒ Supplemental Insurance Rider for Prescription Drugs (H-0300.PD.RD)	$ _____
Application Fee + Monthly Direct Bill Fee (if selected)	$ _____
Total Premium	$ _____

Applicant Information

Applicant Name (First/Middle/Last):	Social Security #:	Birthdate:	❒ Male ❒ Female
Daytime Phone: / E-mail Address:		Ht/Wt:	State or Country of Birth:
Address:	City:	State:	Zip Code:

Tobacco Usage Question

Have you used tobacco in any form within the past 24 months? ❒ Yes ❒ No

Beneficiary Information

Primary Beneficiary Name:	Social Security #:	Relationship:	Birthdate:
Address:	City:	State:	Zip Code:
Primary Applicant - Contingent Beneficiary:	Social Security #:	Relationship:	Birthdate:
Address:	City:	State:	Zip Code:

Hospital Indemnity Health Questions

1. In the past 12 months have you been confined as an inpatient to a hospital, nursing home or have you received home health care, been bedridden or confined to a wheelchair?	❒ Yes ❒ No
2. In the past 12 months have you been treated by a physician for chronic obstructive lung disease, emphysema, Parkinson's Disease, neuromuscular or neurological Disease, insulin dependent diabetes, Alzheimer's disease, ulcerative colitis, cirrhosis or other chronic liver disease?	❒ Yes ❒ No
3. In the past 12 months have you had surgery or have you been advised by a physician to have surgery, including pending biopsy or any pending diagnostic testing?	❒ Yes ❒ No
4. In the past 24 months have you had or been treated by a physician, including injection therapy, for heart attack, stroke, transient ischemic attack, (TIA), heart surgery, congestive heart failure, rheumatoid arthritis, kidney disease, malignant melanoma, internal cancer, autoimmune disorder or osteoporosis causing fractures?	❒ Yes ❒ No
5. In the past 24 months have you received medical advice, treatment or counseling from a physician relating to Schizophrenia, psychotic disorder, bipolar/manic depression, alcohol or substance abuse?	❒ Yes ❒ No
6. Have you been treated for or been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex (ARC) or Human Immunodeficiency Syndrome (HIV) Infection?	❒ Yes ❒ No
7. Are you taking or have you taken any prescription drugs or over-the-counter medications within the last 12 months? If yes, please list the drug and condition. _____ _____	❒ Yes ❒ No
8. In the past 2 years, have you had a Hospital Indemnity insurance application postponed, rated up or declined? If yes, please provide us with details. _____	❒ Yes ❒ No

Supplemental Insurance Rider for Critical Illness Health Question

In the past 5 years have you been diagnosed or received treatment or been advised to have treatment for liver cirrhosis, ALS, Parkinson's Disease, Rheumatoid Arthritis, transplant recipient, multiple sclerosis, muscular dystrophy, lupus, COPD, emphysema, stroke, TIA, paraplegic or quadriplegic, kidney or renal failure, heart or circulatory system disease or internal cancer?	❒ Yes ❒ No

Other Insurance Information

Do you currently have any Hospital Indemnity insurance coverage in force? If Yes, list the name of Company and Policy Number below.	❒ Yes ❒ No

Existing Coverage Insurer's Name:	Policy/Certificate #:

Is this coverage being applied for intended to replace any existing or pending accident or sickness insurance? If Yes, list the name of Company and Policy Number below.	❒ Yes ❒ No

Existing Coverage Insurer's Name:	Policy/Certificate #:

Agent Information

To the best of your knowledge, will the insurance applied for replace or change existing insurance? ❒ Yes ❒ No
If "Yes", submit complete requirements of the state where the application was signed.

I certify that I have truthfully and accurately recorded the answers provided by the applicant(s) in this application.

Writing agent name: _____ Signature: _____ Date: _____

Agent _____ Percent _____ License No. _____

Agent _____ Percent _____ License No. _____

Billing Information

Payment Mode: ❒ Monthly ❒ Quarterly ❒ Semi-Annual ❒ Annual	Payment Type: ❒ Monthly Bank Draft ❒ Direct Bill

Payor if other than Applicant:	Payor's Name _____ Payor's Address _____ Daytime Phone _____ Relationship _____

Pre-Authorization (PAC) Check Payment Plan

Primary Applicant Name *(as it appears on bank account)* _____

Account Number _____

Name of Financial Institution (Bank) _____

Address of Financial Institution (Bank) _____

I hereby authorize Philadelphia American Life Insurance Company to initiate debit entries to my account indicated above, and I authorize the Financial Institution named above to charge the amount of such entries to my account. I further authorize Philadelphia American Life Insurance Company to initiate credits to my account to correct errors, and Institution to deposit any such corrections to my account.

This authority is to remain in full force and effect until I revoke the agreement as hereafter provided. Any revocation is effective only after Company has received written notice from me to terminate this agreement in such time and manner to afford a reasonable opportunity to act upon the notice. I have the right to stop payment of a debit entry by notification to Institution in such time and manner to afford a reasonable opportunity to act prior to charging the account.

✕	✕	
Signature	Second Signature for Joint Account	Date

(*Attach voided check or deposit slip*)

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.

Notice to Applicant Regarding Replacement of Health 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.

Acknowledgement and Authorizations

I hereby apply to Philadelphia American Life Insurance Company (the 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 the 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 Human Immunodeficiency Virus (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 a Human Immunodeficiency Virus-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 the Company or it's representative or it's reinsurers upon presenting this authorization or a photocopy. The Company or its reinsurers may make a brief report available regarding me 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 the 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 acknowledge receipt of the Outline of Coverage and have read the Notice to Applicant Regarding Replacement of Health Insurance if this is a replacement.

I hereby attest that I currently have other health coverage in force that qualifies as "minimum essential coverage".

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 which subjects such person to criminal and civil penalties.

X _____	_____	_____
Applicant Signature	Signed at (City and State)	Date
X _____	_____	_____
Witness (Licensed Resident Agent)	Owner, if other than Primary Applicant	Date