ACA
Insurance Group

Agent:	Date:

Client Information Form

Full Name (Primary):					
Marital Status:	Single ☐ Married ☐				
Spouses Name:					
Phone#:		**ALT:**			
Address:					
City:					
State:		**Zip:**			
Email*					
Birth date:					
# of people needing coverage:					
Primary Social Security #:					
Dependants:	**Name:**	**Birth date**	**SS#**	**Sex**	**Needs Coverage**
				M / F	☐
				M / F	☐
				M / F	☐
				M / F	☐
Employer :		**Phone#:**			
Household Income:	$				

Primary Care Physician(s)	**Name:**	**Specialty:**
Physical Ailments requiring treatment		
Prescriptions	**Name:**	**Dosage:**

ACA
Insurance Group

Agent Use Only Below				
Client Name				
Plan:				
Subsidy :				
Premium:				
Application ID:				
Notes:				
EFT	Bank:			
	Account#:	Routing#:		
Payment	Visa, MC, Disc	CC#	Exp /	CCV

This form is used for the sole purpose as reference information for providing customer service with health and supplemental insurance products. It will not be used for any other reason in compliance the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I hereby authorize the above agent and ACA Benefits LLC or agent of, to oversee all aspects of my enrollment and coverage in the healthcare marketplace or heathcare.gov. By signing this document I give full authority to the above agent to sign on my behalf for the only purpose of enrolling me in healthcare:

Sign:_____ Print Name:_____ Date:_____
Agent :_____ Print Name:_____ Date:_____

ACA Benefits LLC

10 Strecker Ave, Suite 1090
Ellisville, Mo 63011
Office: (314) 779-4722
Email: Info@acainsuresme.com
www.ACAinsuresme.com

Primary Applicant Name_____
Application Form ID_____

Cigna Health and Life Insurance Company (Cigna)

Missouri Application for Dental Insurance

Section A. Dental Coverage Options:

1. Select who the coverage is for:
☐ Primary Applicant Only ☐ Primary Applicant and Dependent(s) ☐ Child(ren) Only

2. Select what coverage applicant(s) is/are applying for:
☐ New Dental Coverage ☐ Add Family Member(s) to existing dental policy ☐ Add dental coverage to existing medical policy
☐ Request Plan Change ☐ Reinstatement

Policyholder's Name: _____ ID Number: _____

3. Select Requested Effective Date:*
☐ 1st of the Month of _____
*Next available effective date will be assigned if not selected by the applicant.

Section B. Benefit Plan Option:

☐ myCigna Dental Preventive
☐ myCigna Dental 1000
☐ myCigna Dental 1500

Section C. Applicant(s) applying for coverage: Dependent children are eligible for coverage up to age 26.

Last Name	First Name	M.I.	Age	Date of Birth (MM/DD/YYYY)	Gender	Social Security Number
Primary Applicant					☐ Male ☐ Female	
Custodial Parent or Legal Guardian Name (for applicants under the age of 18):					Relationship to Applicant:	
Spouse/Domestic Partner/Civil Union					☐ Male ☐ Female	
Dependent 1					☐ Male ☐ Female	
Dependent 2					☐ Male ☐ Female	
Dependent 3					☐ Male ☐ Female	
Dependent 4					☐ Male ☐ Female	

☐ Check here if you are providing names of additional dependents on an attached separate page.

Section D. Primary Applicant's Information:

Home Address Required:

_____
Street

_____
City State ZIP Code

_____
Preferred Household Email Address*:

Mailing Address (if different than Home Address):

_____
Street

_____
City State ZIP Code

_____ _____ _____
Cell Phone Home Phone Work Phone

*By providing your e-mail address, you agree to receive electronic communications about your application status, enrollment and Cigna health benefit plans, products and services.

Primary Applicant's marital status: ☐ Married ☐ Single

Section E. Prior / Current Coverage Information

E1. Do you have prior or current dental coverage? ☐ Yes ☐ No

E2. If any applicant answered "Yes" to the above question, please provide the following information:

Most recent dental coverage start date: (MM/DD/YYYY) _____ Termination date: (MM/DD/YYYY) _____

Name of prior or current dental plan carrier: _____ Policy Number: _____

Type of prior or current dental policy: ☐ Discount dental plan ☐ Preventive only dental plan ☐ Full coverage dental plan
☐ Other (please explain) _____

E3. Does this information apply to all family members on this application? ☐ Yes ☐ No

If "No", please indicate which family members are covered under the same prior or current dental plan:

_____

☐ Check here if you are providing details to the information above for other family members on an attached separate page.

E4. Do you have current medical coverage? ☐ Yes ☐ No

Section F. Payment Method

NOTE: Electronic Funds Transfer - EFT (Automatic draft from a checking or savings account) and Credit Card are the only initial payment methods allowed for online or faxed applications. The accounts will be charged upon approval of your Application.

Please select your payment method from the below options:

Premium Payment Frequency:

☐ Monthly

Inital Premium Payment Method:

☐ Electronic Funds Transfer (EFT) ☐ Automatic Credit Card Payment ☐ Paper Check

Electronic Funds Transfer - EFT (Automatic draft from a checking or savings account)

☐ Yes, I am requesting EFT for both for my initial payment and for ongoing recurring monthly payments (no paper or electronic monthly billing statement will be issued).

☐ Yes, I am requesting EFT for my initial payment. I agree that I am responsible for initiating all subsequent electronic monthly payments. I am requesting monthly electronic bills (eBills) to be sent to my email account as provided in Section D of this application.

Account Number:_____ ☐ Checking ☐ Saving

Routing Number: ☐☐☐☐☐☐☐☐☐

Name of Bank:_____ Name(s) on Account:_____

I authorize the Company (Cigna) to make premium withdrawals, in the amount of the premium payment noted above, from my bank account as identified on this form and authorize the banking facility (Bank) to charge such withdrawals to my account. This authority will remain in effect until the Company receives written notice from me that the authority is terminated. Such termination will be effective with respect to the next premium due following 21 days after the written notice is received by the Company. I understand that if for any reason, a withdrawal is not honored by the Bank (including, but not limited to, insufficient funds or my direction to the Bank not to honor the withdrawal) my health care contract premium will be unpaid, and failure to pay my health care contract premium may result in termination for my health care contract, and that this authorization will remain in place until cancelled and that any due or past due premiums may be withdrawn under this authorization. I understand and agree that termination of this authorization does not relieve me of responsibility for charges incurred under my health care contract. I agree to indemnify and hold harmless the Company and its affiliates and employees for any claims arising out of transfers or deductions from my account in accordance with this authorization.

Credit Card

Name on Credit Card: _____ Expiration Date: _____

☐ VISA ☐ MASTERCARD

Card Number: ☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐

3-digit Code: _____ ZIP Code: _____

For Paper Application: ***Please check here:*** ☐ **Paper check is attached** **or** ☐ **Credit card information provided.**

Ongoing Payment Options if paying by paper check or credit card for initial payment (please select one option only)

☐ **Monthly Paper Bill:** Yes, I am submitting a paper check (or have selected the Credit Card option) for my initial payment. I will submit a check for my ongoing monthly payments.

☐ **EFT Draft:** Yes, I am submitting a paper check for my initial payment (or have selected the Credit Card option) and I am requesting recurring automatic EFT drafts for ongoing monthly payments. (No paper or electronic monthly or quarterly billing statements will be issued.) Please complete EFT Section.

☐ **Monthly Electronic Bill (eBill):** Yes, I am submitting a paper check (or have selected the Credit Card option) for my initial payment and agree that I am responsible for initiating all subsequent electronic monthly payments. I am requesting monthly electronic bills (eBills) to be sent to my email account provided in section C of this application.

☐ **Credit Card:** Yes, I agree to recurring automatic Credit Card drafts for my ongoing monthly payments. (No paper or electronic monthly billing statement will be issued.) Please complete the Credit Card section above.

For Online electronic submitted Application:
Ongoing Payment Options if Credit Card Option was selected for initial payment (please select one option only).

☐ **EFT Draft:** Yes, I agree to recurring automatic EFT drafts for my ongoing monthly payments. (No paper or electronic monthly billing statement will be issued.) Please complete the EFT section above.

☐ **Monthly Electronic Bill (eBill):** Yes, I agree that I am responsible for initiating my ongoing electronic monthly payments. I am requesting monthly electronic bills (eBills) to be sent to my email account as provided in section C of this application.

☐ **Credit Card:** Yes, I agree to recurring automatic Credit Card drafts for my ongoing monthly payments. (No paper or electronic monthly billing statement will be issued.) Please complete the Credit Card section above.

Section G. Statement of Accountability – *To be completed when applicant can not complete this application.*

I, _____, personally read and completed this Application form for the Applicant named below because:

☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English

☐ Other (explain):_____

I personally translated the contents of this application and, to the best of my knowledge, obtained and listed all the personal information disclosed by:

_____

I also personally translated and fully explained the "Conditions and Agreement/Authorization Section":

_____ _____

Signature of Translator *required*
(Excludes Parent Signature if Child Only Application)

Today's Date required

Section H. Producer Information

Writing Producer Name:	Producer Code:
Email Address:	
Phone Number:	

Are you aware of any information about your client not disclosed on this application? ☐ Yes ☐ No
If "Yes", please explain:_____

I certify any information recorded by me on this application is true and accurate to the best of my knowledge and belief. I verify that the applicant has received any required Outline of Coverage.

Signature of Licensed Producer:	Date: (MM/DD/YYYY)

Section I. Conditions and Agreement/Authorization

1. I understand that any person who knowingly and with intent to defraud any insurance company or other person files application for insurance or statement of claim containing any material false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits fraudulent insurance act and may be subject to civil and criminal penalties.
2. I understand that I or my authorized representative is entitled to receive a copy of this authorization form.
3. I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and will no longer be protected by federal privacy regulations.
4. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent).

I acknowledge and agree that coverage shall become effective only after (a) this signed Application has been accepted by Cigna, and (b) a contract has been issued by Cigna.

I AGREE ON BEHALF OF MYSELF AND AS AUTHORIZED AGENT OR REPRESENTATIVE OF MY ELIGIBLE DEPENDENTS TO THE PROVISIONS CONTAINED ON THIS FORM, INCLUDING THE PROVISIONS REGARDING THE COLLECTION, USE, AND DISCLOSURE OF PROTECTED HEALTH INFORMATION.

All applicants 18 years and older must sign and date application. Applicants under the age of 18 require custodial parent or legal guardian signature acknowledging their understanding of and agreement to the conditions listed above.

The above statements are true and complete to the best of my knowledge and belief. I understand and agree that for my child, and/or me and my eligible dependents, these statements shall be the basis for determination of acceptance for coverage under my applicable Cigna benefit plan. I acknowledge and agree that any misrepresentation or intentional omission may render this contract null and void from its date of issue in accordance with applicable law. If my coverage is revoked, I will receive written notice that will explain the decision and my right to appeal. I also understand that I will be required to pay for any services that were covered while a member and that Cigna will refund all amounts paid by me except amounts owed to Cigna.

Primary Applicant Signature:	Today's Date: (MM/DD/YYYY)	Spouse/Domestic Partner/Civil Union Signature:	Today's Date: (MM/DD/YYYY)
Custodial Parent or Legal Guardian Signature (for applicants under the age of 18):			Today's Date: (MM/DD/YYYY)
Dependent Age 18 or Older Signature:	Today's Date: (MM/DD/YYYY)	Dependent Age 18 or Older Signature:	Today's Date: (MM/DD/YYYY)

Section J. Instructions:

- **Mail or FAX this application to:**
  Cigna Individual and Family Plans
  P.O. Box 30362
  Tampa, FL 33630-3362
  FAX: 1-877-484-5927
- Fill in all information and print clearly using black or blue ink.
- The applicant is responsible for ensuring that the application is complete and truthful.
- Coverage will become effective only if this application is approved.
- Coverage is not guaranteed until you receive written notification from Cigna. Do not cancel your current coverage until you have received written notification from Cigna.
- Requested Effective Date cannot be greater than 60 days after the signature date. No Effective Dates will be assigned prior to or on the Signature date.
- If you have questions about completing this application, please call Cigna at 1-866-GET-Cigna (1-866-438-2446) 8 am - 8 pm ET, Monday – Friday.

ACA BENEFITS, LLC

Rapp PAYROLL SOLUTIONS

HEALTH INSURANCE PREMIUM DEPOSIT INFORMATION

NAME					
ADDRESS					
CITY					
EMPLOYER					
DRIVERS LICENSE/ STATE ID#		EXPIRE		ISSUE	
SS#					
DOB					
HOME PHONE					
WORK PHONE					

Cigna Supplemental Solutions®
Insured by Loyal American Life Insurance Company

Application Booklet for Cash Advantage®
CRITICAL ILLNESS in MISSOURI

- APPLICATION
- ELECTRONIC FUNDS TRANSFER FORM
- HIPAA NOTICE
- REPLACEMENT NOTICE

BEING TRUE TO **YOURSELF** IS THE FIRST STEP TO BEING TRULY **HEALTHY.**

GO YOU®

Cigna®

SPECIFIED CRITICAL ILLNESS INSURANCE POLICY

Insured by Loyal American Life Insurance Company®

PO Box 559015, Austin, TX 78755-9015 • (866) 459-4272

PV Case # _____

Application for Insurance

Application is for: ☐ New Business ☐ Reinstatement ☐ Benefit Change

Section 1. Applicant's Information

Applicant's Name First	MI	Last	Sex	Date of Birth Month	Day	Year	Age	Height	Weight

Mailing Address _____

City _____ State _____ Zip _____

Soc. Sec. # _____ Email Address _____

Employer/Job _____ Title/Duties _____

Daytime Phone _____ Evening Phone _____

Best Time to Call *(provide a 2+ hour time period)*: from _____ ☐ AM ☐ PM to _____ ☐ AM ☐ PM

☐ Payor or ☐ Owner *(if other than Applicant)* Payor/Owner Relationship _____

Payor/Owner Name _____ Mailing Address _____

City _____ State _____ Zip _____

Beneficiary (Full Name) _____ Relationship _____

EMPLOYMENT STATUS

Do you work outside your home a minimum of 30 hours per week? ..... ☐ YES ☐ NO

If NO, please explain _____

Have you been actively at work for the last 30 days? ..... ☐ YES ☐ NO

If NO, please explain _____

SPOUSE INFORMATION

Name of Spouse	Date of Birth Month	Day	Year	Ht.	Wt.	Employer	Job Title	Duties

DEPENDENT CHILD(REN) TO BE COVERED

Name of Child(ren)	Date of Birth MM/DD/YYYY	Full-time Student? Yes	No	Name of Child(ren)	Date of Birth MM/DD/YYYY	Full-time Student? Yes	No
1.		☐	☐	4.		☐	☐
2.		☐	☐	5.		☐	☐
3.		☐	☐	6.		☐	☐

Section 2. Coverage Type *(select one of the following)*

☐ Family ..... You, your Spouse, and your Child(ren) are applying

☐ One Parent ..... You and your Child(ren) are applying

☐ Individual ..... You are applying for yourself only

Section 3. Rate Class *(select one of the following)*

☐ Non-Tobacco ..... You or your Spouse, if applying, **have not** used tobacco within the last five years

☐ Tobacco ..... You or your Spouse, if applying, **have** used tobacco within the last five years

Section 4. Benefit Selection

Critical Illness **Benefit Amount $**_____

(if applying, Spouse benefit same, Child(ren) benefit amount is $10,000)

RIDERS

☐ **Hospital Indemnity Rider** ☐ $100/day ☐ $200/day ☐ $300/day ☐ $400/day ☐ $500/day ☐ $600/day ☐ $700/day ☐ $800/day ☐ $900/day ☐ $1,000/day

☐ **Accidental Death & Dismemberment Rider** ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000

(if applying, Child(ren) benefit amount is $25,000)

Section 5. Effective Date Request *(select one of the following)*

☐ Date of Application ☐ Date of Approval ☐ List Bill (the Effective Date will be determined by Home Office)

☐ Requested Effective Date _____ (no more than 60 days from date of Application)

Section 6. Non-Medical Questions

	YES	NO
6a. Do you or any Applicant currently have any Supplemental Critical Illness coverage in force?	☐	☐
If YES, list the name of Company and Policy Number _____		
6b. During the past five (5) years, has any Applicant had a Supplemental Critical Illness Insurance Application postponed, rated up?...	☐	☐
6c. Is the Insurance applied for here intended to replace any existing or pending accident or sickness insurance?	☐	☐
If YES, complete the provided Replacement Notice and list the name of Company and Policy Number: _____		
6d. Is any Applicant eligible for Medicare?	☐	☐
If YES, review the *Guide to Health Insurance for People with Medicare* which is available from the company.		

Section 7. Medical Questions *(if any question in Section 7 is answered YES, the Applicant that it applies to is **not** eligible for coverage)*

Complete the following Part(s) based on the type of underwriting available to Applicant:

Modified Guaranteed Issue (MGI): Eligible employee/member and employee/member Spouse ..... **Part A**

Simplified Issue (SI): Applicant(s) applying for Critical Illness only ..... **Parts A & B**

Full Underwriting: Applicant(s) applying for Critical Illness and additional Rider Benefits ..... **Parts A, B, C, & D**

PART A (please answer the following questions)

	YES	NO
7a. Have you or any Applicant ever been diagnosed with, treated for, or taken prescription medication for any of the following:		
i. internal or blood cancer, leukemia, Hodgkin's disease, melanoma, malignant tumors, or carcinoma in situ?	☐	☐
ii. disease or disorder of the heart, heart attack, CAD (coronary artery disease), heart condition, heart valve disorder, stroke, TIA (transient ischemic attack), paralysis, or muscular abnormalities?	☐	☐
iii. disease or disorder of the circulatory system, blood clots, or been prescribed three or more medications to be taken concurrently for high blood pressure?	☐	☐
7b. Have you or any Applicant ever been advised to have any diagnostic tests related to cancer which have not been completed or for which results have not been received or are other than normal?	☐	☐
7c. Have you or any Applicant ever had elevated PSA levels greater than 4.0 or been diagnosed with Dysplasia of the cervix classified as level 3 or 4?	☐	☐

PART B (please answer the following questions)

	YES	NO
7d. Have you or any Applicant ever been diagnosed with, treated for, or taken prescription medication for any of the following:		
i. chronic obstructive pulmonary disease (COPD), emphysema, pulmonary fibrosis, pulmonary hypertension, diabetes, kidney failure or polycystic disease, chronic kidney disease, connective tissue diseases such as systemic lupus or cystic fibrosis?	☐	☐
ii. liver disease including cirrhosis or hepatitis (other than type A), alcohol or drug abuse?	☐	☐
iii. macular degeneration, glaucoma, or permanent and uncorrectable loss of sight or corrected visual acuity worse than 20/200 in both eyes or do you have a field of vision less than 20 degrees in both eyes?	☐	☐

7e. Within the last six (6) months, have you or any Applicant had or been advised of the need to have diagnostic tests performed to evaluate symptoms of chest pains, shortness of breath, blackouts, fainting, or dizziness? ☐ ☐

7f. Have you or any Applicant ever had an Organ transplant, bone marrow transplant, or been advised you need a transplant? ☐ ☐

7g. Do you or any Applicant now have or at any time have been diagnosed with or received medical advice or treatments from a physician or an appropriately-licensed clinical professional acting within his/her scope for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infection? ☐ ☐

PART C (complete if applying for Hospital Indemnity Rider *(in addition to Parts A & B)*) YES NO

7h. Are you or any Applicant currently confined in or scheduled for admission to a hospital or nursing facility, or receiving Home Health Care services? ☐ ☐

7i. Has any Applicant been advised to have surgery that has not been performed? ☐ ☐

7j. Does any Applicant anticipate having surgery within the next twelve (12) months? ☐ ☐

7k. Are you or any Applicant bedridden or require the assistance of a wheelchair or walker? ☐ ☐

7l. Within the past two (2) years, have you or any Applicant:
i. been confined to a nursing facility? ☐ ☐
ii. been hospitalized more than two (2) times? ☐ ☐
iii.had any amputation caused by disease? ☐ ☐

7m. Are you or any Applicant to be insured under this benefit currently pregnant or undergoing infertility treatment? ☐ ☐

PART D – complete if applying for Accidental Death and Dismemberment Rider *(in addition to Parts A & B)*: YES NO

7n. Has any Applicant been charged with driving under the influence (DUI) of drugs or alcohol within the last (10) ten years? ☐ ☐

7o. Have you or any Applicant participated in or intend to participate in and/or is currently participating in piloting, parachuting, skydiving, hang gliding, motor racing, or any other similar hazardous type sport(s) or activity(ies)? ☐ ☐

Section 8. Premium Payment Method *(select one of the following)*

☐ Electronic Funds Transfer (Bank Draft) *(complete the Electronic Funds Transfer Authorization form)*
Premium Mode: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

☐ Direct Bill
Premium Mode: ☐ Quarterly ☐ Semi-annually ☐ Annually

☐ List Bill *(payroll deduction)*
Premium Mode: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually ☐ 26 Pay ☐ 52 Pay
Group Name _____ Group Number_____ Is this a Section 125? ☐ Yes ☐ No

Section 9. Additional Premium Information

Modal Premium $ _____ Payment with Application $ _____

☐ Check enclosed *(make checks Payable to **Loyal American Life Insurance Company**)*

Section 10. Applicant's Statement and Agreements

I hereby apply to Loyal American Life Insurance Company ("the Company") for insurance for coverage to be issued based upon the truth and completeness of the answers to the above questions and understand and agree that: (1) no Agent has the authority to waive the answer to any questions on the Application; (2) no insurance will be effective until (a) my Application has been approved by the Company, (b) the initial premium has been paid, and (c) the policy has been issued by the Company; and (3) I have received the Outline of Coverage for the policy applied for and, if eligible for Medicare, the required *Guide to Health Insurance for People with Medicare*.

THIS POLICY PROVIDES LIMITED BENEFITS. REVIEW YOUR POLICY CAREFULLY.

FRAUD WARNING: I KNOW THAT ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURER SUBMITS AN APPLICATION FOR INSURANCE CONTAINING FALSE OR DECEPTIVE STATEMENTS MAY BE GUILTY OF INSURANCE FRAUD.

In the event that I am applying for the Hospital Indemnity Rider, the following disclosure and attestation apply:

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.

I hereby attest that I have other health coverage that is minimum essential coverage within the meaning of section 5000A(f) of the Internal Revenue Code, or that I am treated as having minimum essential coverage due to my status as a bona fide resident of any possession of the United States pursuant to Code section 5000A(f)(4)(B).

Signature of Applicant (Proposed Named Insured) _____ Date _____

Affidavit for Agent(s) Use Only: I hereby certify that I have accurately recorded in this Application all of the information known to me and as supplied by the Applicant. The Applicant has read or had read to him or her the completed Application. I also certify that this Application ☐ **does** ☐ **does not** replace or change any existing critical illness coverage.

☐ I certify that I have provided the Applicant with the documents outlined in the Applicant's Statements and Agreements.

I further certify that I have delivered the documents to the Applicant (check all that apply, must select at least one):

☐ In Person ☐ By Mail ☐ Email ☐ Fax Date _____

Was the Application completed by you in the Applicant's physical presence? ..... ☐ YES ☐ NO

Was the Application completed by you over the phone? ..... ☐ YES ☐ NO

Printed Name of 1st Agent	Signature of 1st Agent	Writing Number	Percentage
Printed Name of 2nd Agent	Signature of 2nd Agent	Writing Number	Percentage
Printed Name of 3rd Agent	Signature of 3rd Agent	Writing Number	Percentage

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

LOYAL AMERICAN LIFE INSURANCE COMPANY® • PO BOX 559015 • AUSTIN, TX 78755-9015

Proposed Insured's Name		Policy Number (if available)
Financial Institution Name and Telephone Number		
Financial Institution Address		
9-digit Routing Number	Account Number	Requested Withdrawal Date (1st - 28th)

Withdraw Payment: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Type of Account: ☐ Personal Checking Account ☐ Personal Savings Account ☐ Corporate/Business Checking

Name of Employer Group _____

Purpose for submitting this Authorization (check appropriate box(es)):

☐ New authorization ☐ Change in checking/savings account

☐ Change in financial institution ☐ Change in existing coverage

For Checking Account: Please tape a VOIDED check in this box.

For Savings Account: Please attach a letter from the bank stating the account and routing number of your savings account.

APPLICANT INFORMATION FOR FINANCIAL INSTITUTIONS: As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to Loyal American Life Insurance Company provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. I also authorize Loyal American Life Insurance Company and any financial institution it uses to initiate credit entries to my account or to provide refund of premium or association fees (if applicable). I authorize you to accept and to credit these entries to my account. In the event Loyal American Life Insurance Company mistakenly deposits funds into my account, I authorize Loyal American Life Insurance to debit my account for an amount not to exceed the original amount of credit. This authorization shall 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 draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

APPLICANT INFORMATION FOR LOYAL AMERICAN LIFE INSURANCE COMPANY: It is understood that the drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract and association fees (if applicable), and no other notice of premiums or association fees (if applicable) due will be given. No premium or association fee (if applicable) shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium or association fee (if applicable) payment has been received by Loyal American Life Insurance Company. The cancelled draft will constitute receipt of premium or association fee (if applicable) payment. The privilege of paying premiums and association fees (if applicable) under this Plan may be revoked by Loyal American Life Insurance Company if any draft is not paid upon presentation. The payment of premiums and association fees (if applicable) under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by Loyal American Life Insurance Company upon 30 days written notice.

Name of Payor (if other than Insured) **Payor's Address**

Print name of Depositor (as it appears on account) **Signature of Depositor** **Date**

AUTHORIZATION FORM FOR DISCLOSURE OF AN APPLICANT'S PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of protected health information about me as described below.

1. The Company, as used in this authorization, shall mean American Retirement Life Insurance Company®; or Central Reserve Life Insurance Company; or Loyal American Life Insurance Company®; or Provident American Life & Health Insurance Company.
2. I authorize any licensed physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager, or other medical or medically-related facility, the U. S. Veterans Administration and Selective Service System, insurance company, MIB, Inc., or any other organization, institution, or person that has any records or information available as to the diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment relating to me or my family to disclose to the Company's underwriting, new business, claims, sales agents, and premium accounting representatives any such records or information.
3. The protected health information described above will be disclosed to the Company to determine my or my family's eligibility to obtain coverage under the policy for which I/we have applied, and to determine the rates and terms which apply to the policy.
4. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Privacy Office at PO Box 26580, Austin, Texas 78755-0580.
5. I understand that the information which will be provided under this authorization is necessary for the Company to determine my eligibility for coverage under the policy and that the Company will condition its approval and issuance of the policy on my providing this authorization, and my application may be denied if I refuse to provide this authorization.
6. I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
7. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this authorization upon request. This authorization will expire twenty-four (24) months from the date it is signed.
8. If you are the representative of an Applicant, describe the scope of your authority to act on the Applicant's behalf:

_____

Applicant's Name

Name of Applicant's Personal Representative, if applicable

Applicant's Social Security Number

Relationship of Personal Representative to the Applicant

Signature of Applicant **Date**

Signature of Personal Representative **Date**

Signature of Company's Agent **Date**

A signed copy of this form will be provided with the policy if issued and any other time upon request.

Loyal American Life Insurance Company®
PO Box 559015, Austin, TX 78755-9015 • Toll Free: 866-459-4272

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application and information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Loyal American Life Insurance Company®. Your new policy provides 30 days in which you may decide, without cost, whether or not you decide to keep this policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1) Health conditions which you may presently have may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on any application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____
Date

_____
Applicant's Signature

PAYROLL DEDUCTION FORM

Loyal American Life Insurance Company®

Please complete this form and fax **with the completed applications** to: (512) 467-7403 Attn: Case Coordinator

Employee Authorization for Deduction of Premiums from Salary: I hereby request that you deduct from my salary and forward to Loyal American Life Insurance Company the appropriate premium. Such deductions will cease upon (1) termination of my employment, (2) written notice by me requesting that deductions cease and stating when such cancellation is to be effective*, (3) termination of this payroll deduction plan, or (4) written notice from Loyal American Life Insurance Company.

I understand that premium deduction amounts may change and do hereby consent to such changes without the necessity of additional authorization of my part, verbal or written, provided that the insurance company above certifies in writing that the changes in premium uniformly affect all members of the class to which I belong.

INFORMATION			
Date:	Employee SSN #:		
Employee's Name (print):			
Spouse's Name (if applicable):			
Approximate Monthly Premium:	Employee $	Spouse $	Total $
Employee's Signature:			