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