Standard Life and Accident Insurance Company

**Standard Life and Accident Insurance Company**
**Mailing Address:** P.O. Box 10627, Springfield, MO 65808
888.350.1488

* A P P *

# LIMITED BENEFIT INSURANCE APPLICATION

Please Print — Use Black Ink

☒ New ☐ Reinstatement-Policy Number _____ ☐ Change-Policy Number _____

## SECTION A

1. Applicant NORMA E. MARTINEZ Date of Birth 06/13/1969 Age 46 Sex F Height 4'9 Weight 112
Home Address 482 Poplar Dr City Willing State IL Zip 60090
Phone ( 847 ) 271-4393 Best time to call 12 ☐ a.m. ☒ p.m. Email normamartinez545@gmail.com
Social Security Number 714-30-6885 Occupation NURSE
Billing Address (if different) _____ City _____ State ____ Zip _____

2. Please print the full name of all other Proposed Insureds (Use additional sheet and attach if needed).

| Last, First, Middle Initial | Relationship | Date of Birth Month, Day, Year | Age | Sex M/F | Height (ft.-in.) | Weight (lbs.) | Occupation |
|---|---|---|---|---|---|---|---|
| | Spouse | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

3. **BENEFIT AND PREMIUM DATA** **Billable Premium**
**Plan:** ☒ Plan 1 ☐ Plan 2 ☐ Plan 3 ☐ Plan 4 ☐ Plan 5 $ 73.00
**Billing Mode**: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly PAC ☒ Monthly Credit Card ☐ List Bill
Requested Effective Date 03/11/2016

4. First Beneficiary (Name: last, first, middle initial) ARCO LUIS
Date of Birth 04/26/1991 Relationship SON
Second Beneficiary (Name: last, first, middle initial) _____
Date of Birth _____ Relationship _____

5. Will the insurance applied for replace or change any existing insurance? ..... ☐ **Yes** ☒ **No**
If Yes, list company name and coverage. _____ (company name) _____ (coverage)

6. Do you currently have comprehensive major medical coverage that meets minimum coverage standards under the Affordable Care Act? ..... ☐ **Yes** ☒ **No**

## SECTION B

7. Is any Applicant or Proposed Insured currently pregnant, an expectant parent, or in the process of adopting a child? (If Yes, this coverage cannot be provided)..... ☐ **Yes** ☒ **No**

8. Has any Applicant or Proposed Insured ever taken part in skydiving, hang gliding, parachuting, bungee jumping, rock or mountain climbing, scuba diving, racing (any type), motorcycle riding, professional sports, piloting an aircraft, or rodeo events?... ☐ **Yes** ☒ **No**
If Yes, indicate activity and give details. _____

9. Has any Applicant or Proposed Insured had a driver's license suspended, any traffic violations, DWI/DUI/OUI's or been arrested within the past 2 years? ..... ☐ **Yes** ☒ **No**
If Yes, give details and provide Driver's License Number and state of issue. _____

_____ (Driver's License Number) _____ (State of Issue)

## SECTION C

**If the Applicant or any Proposed Insured answers "Yes" to questions in Section C, that Person is not eligible for coverage.**

10. In the past 2 years, has the Applicant or any Proposed Insured been advised to have any diagnostic/screening tests or procedures which have not yet been performed? ☐ **Yes** ☒ **No**

    If Yes, list name of Applicant or Proposed Insured: _____

11. Within the past 5 years, has the Applicant or any Proposed Insured had abnormal test results, treatment or been recommended to have treatment for any of the following conditions? ☐ **Yes** ☒ **No**

    If Yes, check all that apply and list name of the Applicant or Proposed Insured:

| | | |
|---|---|---|
| ☐ Alcohol or Drug Abuse _____ | ☐ Heart Surgery _____ | ☐ Organ Failure _____ |
| ☐ Alzheimer's Disease _____ | ☐ Hepatitis _____ | ☐ Organ Transplant _____ |
| ☐ Arterial Disease _____ | ☐ Insulin Dependent Diabetes _____ | ☐ Organic Brain Syndrome _____ |
| ☐ Bipolar Disorder/ Manic Depression _____ | ☐ Internal Cancer _____ | ☐ Osteoporosis with History of Bone Fracture _____ |
| ☐ Bone Disease _____ | ☐ Kidney Disease _____ | ☐ Paralysis (any Type of Degree) _____ |
| ☐ Cerebrovascular Accident (CVA) _____ | ☐ Liver Disease _____ | ☐ Peripheral Vascular Disease _____ |
| ☐ Chronic Obstructive Pulmonary Disease (COPD) _____ | ☐ Lou Gehrig's Disease (ALS) _____ | ☐ Rheumatoid Arthritis _____ |
| ☐ Cirrhosis _____ | ☐ Lung Disease (All Others) _____ | ☐ Senile Dementia _____ |
| ☐ Crohn's Disease (Ileitis) _____ | ☐ Lupus Erythematosus _____ | ☐ Stroke _____ |
| ☐ Fibromyalgia _____ | ☐ Major Depression _____ | ☐ Substance Abuse _____ |
| ☐ Heart Attack _____ | ☐ Melanoma Cancer _____ | ☐ Transient Ischemic Attack (TIA) _____ |
| ☐ Heart Disease _____ | ☐ Multiple Sclerosis _____ | ☐ Ulcerative Colitis _____ |
| | ☐ Muscle Disease _____ | |
| | ☐ Muscular Dystrophy _____ | |
| | ☐ Myositis _____ | |

## SECTION D

12. Within the past 5 years, has the Applicant or any Proposed Insured had abnormal test results, been diagnosed with, or received treatment for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) from a physician or an appropriately licensed clinical professional acting within the scope of his/her license? ☐ **Yes** ☒ **No**
13. Is the Applicant or any Proposed Insured taking any prescription medications? ☐ **Yes** ☒ **No**

    If Yes, provide name of Applicant or Proposed Insured and details. _____

14. Has the Applicant or any Proposed Insured been disabled or hospitalized in the last 6 months? ☐ **Yes** ☒ **No**

    If Yes, provide name of Applicant or Proposed Insured and details. _____

## SECTION E - Special Requests

## SECTION F

**DECLARATION AND AGREEMENT** — I/We have personally completed and reviewed all of my/our answers to the questions in this Application and represent that all information I/we have provided is true, complete, and correctly recorded. I/We understand that this information will be used to determine each person's eligibility for coverage under the Policy and any false statement or misrepresentation may result in loss of coverage or claim denial. The Applicant (and Spouse or Dependent if coverage elected) must be eligible based on the Company's rules in effect on the date of Application and on the Policy Effective Date. Policy coverage (or Reinstatment of coverage), if issued and approved by the Company, will become effective on the date recorded in the Policy Schedule of Benefits and not the date this Application is signed. I/We understand that no agent or producer can accept risks, modify policies, or waive any rights or requirements of the Company. If this Application is completed electronically, I/we agree that my/our electronic signature serves as my/our original signature.

**ACKNOWLEDGEMENT** — I/We understand that the coverage applied for provides limited benefits and is not a major medical or comprehensive medical benefit plan and is not a substitute for such coverage. The Policy is limited and is not designed to cover all medical expenses. I/We understand that no benefits are payable for sickness during the first 30 days following the Policy Effective Date and that pre-existing conditions are excluded for 12 months. If eligible for Medicare, I/we have received the *Guide to Health Insurance for People with Medicare* and the Important Notice to Persons on Medicare.

**FRAUD WARNING** — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

**THIS IS A LIMITED BENEFIT POLICY. 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. PLEASE REVIEW THE POLICY CAREFULLY.**

_____ Date

_____ Dated at City, State

_____ Applicant's Signature

_____ Spouse's Signature (if coverage is requested)

## AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I/We hereby authorize any: physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, pharmacy benefit manager, government agency, group policyholder, employer, benefit plan administrator, the MIB, Inc., the Department of Motor Vehicle Registration, and paramedical facility to provide to STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on STANDARD LIFE AND ACCIDENT INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other Proposed Insured for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Applicant or any Proposed Insured. It is understood that STANDARD LIFE AND ACCIDENT INSURANCE COMPANY underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I/We understand that after this information is disclosed, the recipient may redisclose it, resulting in loss of protection by federal regulations.

I/We understand that: **1.** such information will be used by STANDARD LIFE AND ACCIDENT INSURANCE COMPANY for underwriting and insurability determinations; **2.** I/We may refuse to sign this authorization and that my/our refusal to sign will affect my/our ability to obtain health insurance coverage; **3.** a picture copy or photocopy of this authorization shall be as valid as the original; and **4.** I/We, or my/our authorized representative, am/are entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I/We understand I/we may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, P.O. Box 1991, Galveston, Texas 77553. *I/We may inspect or copy any information used or disclosed under this authorization, if signed.* If this application is taken over the phone, I/we agree that my/our electronic signature serves as my/our original signature.

| | |
|---|---|
| Date | Dated at City, State |
| Applicant's Signature | Spouse's Signature (if coverage is requested) |
| SARAH BELTRAN<br>Witness | Personal Representative designated by signature above is hereby authorized to execute this instrument based on: (circle one) power of attorney, guardian, guardian-in-fact, payee representative or other [ ]. |

## AUTHORIZATION TO MY BANK

**PREAUTHORIZED CHECK AUTHORIZATION**

**Attach Voided Check or Deposit Ticket Here and Sign Authorization**

☒ **Checking**

☐ **Savings**

**Bank Information**

CHASE
Name

WILLING | IL | 60090
City | State | Zip

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of Standard Life and Accident Insurance Company, 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 or electronic debit 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 checks. I further agree that should any such checks or electronic debits 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. If application taken over the phone, I agree that my electronic signature serves as my original signature.

Date Signed | ✓ Signature (as it appears on bank records)

Account Number 753319263

Routing Number 071000013

* A G S *

## AGENT STATEMENT

As Agent, do you have knowledge or reason to believe that replacement of existing insurance may be involved? ..... ☐ **Yes** ☒ **No**

If yes, I have complied with all legal and company requirements and the Applicant has read and signed the Notice To Applicant Regarding Replacement.

I hereby certify that all information set forth in the Application is complete and correct to the best of my knowledge and was accurately recorded.

I also certify that I advised the Applicant: **1.** of the eligibility requirements; **2.** that the coverage provides limited benefits and is not a major medical or comprehensive medical plan and; **3.** of the coverage limitations and exclusions, including the waiting period for sickness and pre-existing condition limitation.

SARAH BELTRAN
Agent's Name (please print)

Agent's Signature

C09NU
Agent's Writing Number

03/10/2016
Date Signed

Phone (714) 612-5430

Fax (_____) _____

Email SARAHGUALCO@YAHOO.COM

Premium Quoted: $73.00

☐ **Premium collected with Application.**

☒ **Initial premium is to be:** ☒ **Drafted** ☐ **Charged** **Profile ID**_____

☐ **Credit card initial payment only. Recurring premium bank draft.**

Mail Policy to: ☒ Insured ☐ Agent

Special Request:_____