Application for LUMP SUM CANCER and/or HEART & STROKE INSURANCE POLICY

Heartland National Life Insurance Company
Administrative Office: PO Box 11903, Winston-Salem, NC 27116

Coverage Change
Reinstatement

☐ New Business

(888) 616-0015

Delegan Applicant	Part I –	Person	al Info	rmatio	n			
Primary Applicant								
Last Name			First I	Name				MI
Birthdate (mm/dd/yyyy)	Social Security Numb	per Ag	je	Ge	ender			_
					I Male □	Female		
Daytime Phone			Ev	ening Pl	hone			
Cell Phone			E-1	Mail Add	dress			
Relationship	Name (First, Middle, Las	st)	Date of	Birth	Social Sec	curity Number	Gender	
Spouse/Domestic Partner			/	/	-	-		
Dependent Child #1			/	/				
Dependent Child #2			/	/				
Dependent Child #3			/	/				
Dependent Child #4			/	/				
	Please provide beneficiary information in Please provide beneficiary for Child				Spouse/Dome	stic Partner if app	liable. Primary	
Applicant Name	Name of Beneficiary	Date of	Birth	Rela	ationship	Primary or Continent	Percentage Benefit	of
		/	/					
		/	/					
Physical Address Street Address								
City			Stat	:e	Zip			
Mailing Address (if d	ifferent than above)							
Street Address								
City			Stat	.e	Zip			

Part II – Employment Status (answer only if applying for payroll deduction)						
 Do you work a minimum of twenty (20) hours per week? If "yes", have you been actively at work for the last thirty (30) days? □ Yes □ No □ Yes □ No						
	☐ Yes ☐ No ☐ Retired					
(If, "No", please explain)						
Employer / Job	Title / Duties	Work Location ID (if applicable)				
Part	: III – Other Coverage a	nd Replacement Inforn	nation			
Is any Applicant covered	under a state Medicaid progra	am?	□ Yes □ No			
Is the coverage applied for	or replacing any coverage for	any Applicant?	□ Yes □ No			
If, "Yes", please give details below and complete a Replacement Notice.						
Company	Applicant Name	Type of Insurance	Policy Number			
Please complete the follonswer to any part of Part axplain at the end of Section	wing health questions. Co A, B, C or D is YES. If the on III. Attach a separate sh	verage is not available for answer is YES to any of th neet if needed. IF the answ	r any applicant for whom the ne following questions, please ver is YES to any question for			
•			Applicants			
1. Has any Applicant ever been treated or diagnosed by a Medical Professional for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for the Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No						
immune Deticiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive						
	Employer / Job Part Is any Applicant covered of the coverage applied for the complete the follows any Applicant person of the Human Immunodefic	Part III — Other Coverage at III — Other Coverage at Is any Applicant covered under a state Medicaid progratis the coverage applied for replacing any coverage for If, "Yes", please give details below and complete a Replace Company Applicant Name Part IV — Pre-Qualificatio Please complete the following health questions. Conswer to any part of Part A, B, C or D is YES. If the explain at the end of Section III. Attach a separate shany Applicant person(s) to be covered, that person any Applicant ever been treated or diagnosed by a Medimmune Deficiency Syndrome (AIDS), AIDS Related Corfor the Human Immunodeficiency Virus (HIV)? In B - Complete if applying for Lump Sum Cancer Polit Within the past two (2) years: a. has any applicant ever been advised by a Medical Protreatment or monitoring related to cancer, includ screenings, mammograms, colonoscopies, and generated the completed, for which test results have not been results where cancer has not been ruled out or results b. has any applicant experienced any symptoms related advice, diagnosis or treatment has not yet been obtain not limited to: unexplained weight loss, a lump, groelsewhere; or a change in a mole?	Part III — Other Coverage and Replacement Informal Stany Applicant covered under a state Medicaid program?			

APP-CHS24

Part C - Please complete if applying for the Heart Attack or Stroke Policy*/ Rider	Applicants
Applicant 1: Height (ftin.) Weight (lbs.)	
Applicant 2: Height (ftin.) Weight (lbs.)	
4. During the past five (5) years, has any Applicant been advised by a Medical Professional	
to have any diagnostic testing related to any disease of the heart or circulatory system that has not been completed or for which results have not been received? Or testing	□ Yes
results received that were abnormal or inconclusive?	□ No
5. During the past five (5) years, has any Applicant consulted with a Medical Professional,	
or been diagnosed with, treated for, or hospitalized for:	☐ Yes
a. a heart attack or any disease or disorder of the heart or vascular system, a stroke or Transient Ischemic Attack (TIA), or high blood pressure requiring three (3) or more medications to control?	□ No
 b. Complications of diabetes, diabetic neuropathy, nephropathy, and retinopathy or do you take more than 50 units of insulin per day? 	□ Yes □ No
c. Chronic kidney disease (Stages 4 & 5), kidney failure, or kidney disease requiring	□ Yes
dialysis.	□ No
Part D - Please complete if applying for the Critical Illness Rider	Applicants
6. Within the past two (2) years, has any Applicant had any tests for which results were	□ Yes
abnormal, inconclusive, or not yet known or been advised to have any medical test,	□ Yes
surgery, or other treatment which has not yet been performed?	□ INO
7. Within the past five (5) years, has any Applicant been diagnosed with, treated for, or consulted with a medical professional for:	
 a. emphysema, Chronic Obstructive Pulmonary Disease (COPD), or any other disease or disorder of the lungs (excluding asthma)? 	
b. hepatitis (excluding A), cirrhosis, or any other disease or disorder of the liver?	
c. alcohol or drug abuse or dependency?	☐ Yes
 d. any disease or disorder of the nervous system including neuromuscular disease, Multiple Sclerosis (MS), Systemic Lupus Erythematosus (SLE), Parkinson's disease, and Amyotrophic Lateral Sclerosis (ALS)? 	□ No
e. aneurysm, blood clot, blood disease or disorder?	
f. pulmonary hypertension, pulmonary fibrosis, tuberculosis, or paralysis?	
g. Alzheimer's disease or dementia?	
8. Has any Applicant ever had:	☐ Yes
a. a defibrillator implanted?	□ Yes
b. an organ transplant or been advised of the need for a transplant?	□ INO
During the past five (5) years, has any Applicant had, been diagnosed with, treated for, or taken medication for any of the following:	
aneurysm or pulmonary hypertension?	
b. pulmonary fibrosis or tuberculosis?	☐ Yes
 paralysis or any disorder of the nervous system including Multiple Sclerosis (MS) or Amyotrophic Lateral Sclerosis (ALS)? 	□ No
 d. glaucoma, retinitis pigmentosa, macular degeneration, optic neuritis, or blindness lasting more than 30 days? 	
e. total loss of speech or permanent and total hearing loss in both ears?	
10. Has any Applicant ever had, been diagnosed with, treated for, or taken medication for dementia (including Alzheimer's disease) or any neurological disease or disorder?	□ Yes □ No

*If any answer in Part A is answered "Yes", the application will be Declined. If any answers to the questions in Part B are "yes" then the applicant is not eligible for Cancer coverage. If any answers to questions in Part C are "yes" the applicant is not eligible for Heart Attack or Stroke coverage. If any answers to questions in Part D are "yes" the applicant is not eligible for the Critical Illness Rider.

Part V – Benefits Selection	
Coverage Type: ☐ Individual ☐ Individual & Spouse ☐ One Parent Fa	amily □ Family
Policy Selection - Select Policy(ies) and any applicable Riders	
Cancer Lump Sum	
Choose Benefit Amount	\$ Benefit Amount
(\$5,000 min/\$75,000 max -\$1,000 increments)	
Lump Sum Heart and Stroke Rider	\$ Benefit Amount
(\$5,000/\$75,000 - \$1,000 increments)	φ benefit Amount
Cancer - Return of Premium (select one):	
Payable Upon Death (max issue age 74)	
Payable Upon Termination (20 years) (max issue age 74)	
☐ Cancer – Benefit Builder	□ \$500 □ \$1,000 □ \$1,500
☐ Radiation, Chemo & Experimental	□Essential □Enhanced
(may only be purchased with Lump Sum Cancer Policy)	□Comprehensive
☐ Critical Illness	C Description of
*(benefit amount must be less or equal to the base policy benefit and	\$ Benefit Amount
cannot exceed \$50,000) Heart & Stroke Lump Sum	
neart a otroke Lump oum	\$ Benefit Amount
Choose Benefit Amount	φ benefit Amount
(\$5,000 min/\$75,000 max –\$1,000 increments) Lump Sum Cancer Rider	
	\$ Benefit Amount
(\$5,000/\$75,000 - \$1,000 increments) Heart & Stroke - Return of Premium (select one)	
Payable Upon Death (max issue age 74)	
Payable Upon Termination (20 years) (max issue age 74)	
☐ Heart & Stroke – Benefit Builder	□ \$500 □ \$1,000 □ \$1,500
☐ Critical Illness	
*(benefit amount must be less or equal to the base policy benefit and cannot exceed \$50,000)	\$ Benefit Amount
Premium Worksheet	
Lump Sum Cancer Policy	\$
Heart Attack & Stroke Policy	\$
Lump Sum Cancer Rider	\$
Lump Sum Heart Attack & Stroke Rider	\$
Cancer – Benefit Builder Rider	\$
Heart & Stroke – Benefit Builder Rider	\$
Cancer – Return of Premium Upon Death Rider	\$
Cancer – Return of Premium Upon Termination (20 years) Rider	\$ \$
Heart & Stroke – Return of Premium Upon Death Rider	\$
Heart & Stroke – Return of Premium Upon Termination (20 years) Rider	\$ \$
Radiation, Chemo & Experimental Rider	\$ \$
Critical Illness Rider	\$ \$
Total	\$

	Part VI – Premium Paym	nent & Administration					
REQUESTED EFFECTIVE (if other than Application		1					
*The	e effective date cannot be more that	an 60 days from the application date.					
PAYMENT TYPE: ☐ Ba	PAYMENT TYPE: ☐ Bank Draft ☐ Direct Bill						
PREMIUM MODE: ☐ M	lonthly □ Quarterly □ Semi-Ar	nnual □ Annual					
		APPLICANTS					
TOTAL AMOUNT SUBM	IITTED:	\$					
SUBSEQUENT PAYMED Drafted/Pay of the state o	NTS**: on the day of the month OR the nents can be drawn between the 1s		card				
Name(s) of Depositor(s):							
Bank Routing Number: (first 9 digits)		Bank Account Number: do not include check #)					
	☐ Checking Account	☐ Savings Account					

	Part VII – Agreement & Acknowledgem	ient	
	ess, Heartland National Life Insurance Company ha o purchase this policy. Please indicate your receipt		n that you should
☐ Outline of Coverage	☐ If over age 65, A Guide to Health Insurance for	or People with Me	dicare
	s application are incorrect or untrue, the Company has limited benefits. Review your policy carefully.	as the right to deny l	penefits or rescind
I HAVE READ AND FULLY U knowledge and belief they are	NDERSTAND the questions and my answers on true and complete.	this Application. T	o the best of my
above questions; (2) no coveraging (3) any misstatement of fact in	that: (1) this coverage will be issued based solely ge will exist until a policy is issued, and will be in for this application may result in the denial of benefits or a pre-existing condition will not be covered for the	ce only as of the postor or cause the Com	olicy effective date; pany to change or
COVERAGE. LACK OF MAJO	O HEALTH INSURANCE AND IS NOT A SUI OR MEDICAL COVERAGE (OR OTHER MINIMU PAYMENT WITH YOUR TAXES.		
	medical health insurance or Medicare that meets the eral Affordable Care Act. Any Applicant who is curren		
Heart and Stroke Benefit Builde Waiting Period which begins on	Sum Heart and Stroke Policy/Rider, Lump Sum Can er Riders, and Radiation, Chemotherapy & Experime the issue date. No benefits will be paid for any loss to irst 30 days following an Insured Person's issue date	ental Benefit Rider h that begins during tl	nas have a 30-day
	overage. If this application is completed electronically or with the policy. If the application is completed over		
completed by electronic device of in accordance with any applicate provided my consent and authorized signature is legally binding, and completed by telephonic mean having the same effect as if I Heartland National communic Communications Disclosure, where the same of t	etronic Signatures, Policy Fulfillment and Common telephonic means. I acknowledge Heartland Nationale federal or state law and that if this Application is contraction to complete an electronic transaction to ad has the same effect as if I had physically signed is, I authorize Heartland National or its agent to achad physically signed this Application. I agree that eations electronically. I also acknowledge receiphich describes the requirements for Electronic Policy extronic Policy Fulfillment and Communications and its statements.	nal or the agent has completed by electron poly for this covers this Application. If the cept my voice sign at I may receive my ipt of the Electron y Fulfillment and Co	verified my identity onic means, I have age. My electronic this Application is lature response as y Policy and other onic Delivery and ommunications, as
	resents a false or fraudulent claim for payment of an application for insurance is guilty of a crime n or any combination thereof.		
Signed at (City and State):		Date:	/ /
Applicant 1's Signature:			
Applicant 2's Signature:		Send Policy(ies) to:	☐ Applicant(s)☐ Producer
Producer's Signature:		_	
Producer Number:	Producer's F	Phone: ()	

/ / \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Yes					er Supplemen			
1. Did you meet with the Applicant(s) in person? 2. Did you complete this Application over the phone? 3. State the name and relationship of any other person present when this application was taken. Name: Relationship to Applicant(s): 4. Did you review the Application for correctness and any omissions? 5. Did the Applicant(s) review the application for correctness and any omissions? 6. Are you related to Applicant(s)? If "Yes", provide relationship: 7. Will this policy replace an existing Accident and Health insurance policy? If "Yes", complete Replacement Notice Listed below are all other health insurance policies or certificates I have (a) sold to the Applicant(s) which are still force; and (b) sold to the applicant(s) in the last 5 years which are no longer in force: Company Type of Policy Effective Date In Force / / Yes Yes		No			All ques	tions must be co	ompleted.		
□ □ 3. State the name and relationship of any other person present when this application was taken. Name:			1.						
Name:			2.						
4. Did you review the Application for correctness and any omissions? 5. Did the Applicant(s) review the application for correctness and any omissions? 6. Are you related to Applicant(s)? 1f "Yes", provide relationship: 7. Will this policy replace an existing Accident and Health insurance policy? If "Yes", complete Replacement Notice Listed below are all other health insurance policies or certificates I have (a) sold to the Applicant(s) which are still force; and (b) sold to the applicant(s) in the last 5 years which are no longer in force: Company Type of Policy Effective Date In Force of the Applicant of			3.	State the name and rela	ationship of any other	er person present	when this applicatio	n was taken.	
□ □ 5. Did the Applicant(s) review the application for correctness and any omissions? □ □ 6. Are you related to Applicant(s)?				Name:					
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Type of Policy Company Type of Policy Froducer #1 Name (please print) 7. Will this policy replace an existing Accident and Health insurance policy? If "Yes", complete Replacement Notice Listed below are all other health insurance policies or certificates I have (a) sold to the Applicant(s) which are still force; and (b) sold to the applicant(s) in the last 5 years which are no longer in force: Type of Policy Effective Date In Force / / Yes / Producer Number Split %			6.	Are you related to Applie	cant(s)?				
force; and (b) sold to the applicant(s) in the last 5 years which are no longer in force: Company Type of Policy Effective Date In Force			7.	Will this policy replace a	n existing Accident	and Health insura	ance policy?		
) which are still i	n
Producer #1 Name (please print) Producer Number Split %			С	ompany	Type of	Policy	Effective Date	In Force	
Producer #1 Name (please print) Producer Number Split %							/ /	☐ Yes ☐ I	No
Producer #1 Name (please print) Producer Number Split %							/ /	☐ Yes ☐ I	No
<u> </u>							/ /	☐ Yes ☐ I	No
Producer #2 Name (please print) Producer Number Split %	Prod	lucer #	‡1 Na	ame (please print)		Producer Numb	per	Split %	
	Prod	lucer #	‡2 Na	ame (please print)		Producer Numb	per	Split %	

HEALTH INFORMATION AUTHORIZATION

This Authorization complies with the HIPAA Privacy Rule

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit managers, medical facility, or other health care provider that has provided services, treatment or payment to me, or on my behalf, within the past 10 years ("My Providers"), or consumer reporting agency, or the Medical Information Bureau, to dis- close my entire medical record and any other protected health information concerning me to Heartland National Life Insurance Company ("Heartland") and its agents, employees and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

My protected health information is to be disclosed under this Authorization so that Heartland may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill their responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Heartland.

For a period of 120 days from the date of this Authorization I authorize my Heartland Producer to receive certain protected health information about me that is related to an adverse underwriting decision or counteroffer for alternative coverage made during the underwriting of my application.

This Authorization shall remain in force for 30 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to: **Heartland at PO Box 11903**, **Winston-Salem**, **NC 27116**, **Attention: Privacy Officer.** I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that Heartland has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, Heartland may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

Name of Applicant (please print)	Signature of Applicant or Personal Representative
Date of Birth	Date
Description of Personal Representative's	Authority or Relationship to Applicant (if applicable)

(Return to Company)

H-HHA17



PO BOX 11903 Winston-Salem, NC 27116

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE!

According to Your application, You intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Heartland National Life Insurance Company. For Your own information and protection, You should be aware of and seriously consider certain factors that may affect the insurance protection available to You under the new policy.

- (1) Health conditions which You may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present 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 agents regarding the proposed replacement of Your present policy. This is not only Your right, but it is also in Your best interests 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 an 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	Agent Name (Print)
Applicant's Signature	Agent's Signature

HRN 17



PO BOX 11903 WINSTON-SALEM.NC 27116

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Date	Agent Name (Print)
	Agent's Signature

HRN 17