UNL
UNITED NATIONAL LIFE

# Application for Limited Home Health Care Indemnity

United National Life Insurance Company of America
1275 Milwaukee Avenue Glenview, IL 60025
(800) 207-8050

**AGENT NOTE:** Please pre-qualify the Applicant(s) in step 3 prior to completing the application.

**Application for:** ☐ New Coverage ☐ Increase Benefits

If increase of benefits requested, please list UNL policy/certificate number(s) affected: _____

**SEND POLICY TO:** ☐ **AGENT** ☐ **INSURED**

## Applicant 1

Full Legal Name of Applicant _____
First MI Last

Social Security Number_____ -_____ -_____ Age _____ Date of Birth _____ /_____ /_____ ☐ Male

Height ft.____in.____ Weight _____lbs. Beneficiary _____ ☐ Female

## Applicant 2

Full Legal Name of Applicant _____
First MI Last

Social Security Number _____ -_____ -_____ Age _____ Date of Birth _____ /_____ /_____ ☐ Male

Height ft.____in.____ Weight _____lbs. Beneficiary _____ ☐ Female

## Address

Home Address _____
Street City State Zip

Applicant 1 E-mail Address _____ Applicant 2 E-mail Address _____

Applicant 1 Phone Number _____ Applicant 2 Phone Number _____

## Step 1: Choose Home Health Care Benefit

| | Applicant 1 | Applicant 2 |
|---|---|---|
| Premium Payment Mode | ☐ Annual ☐ Quarterly ☐ Semi-Annual ☐ Monthly Bank Draft | ☐ Annual ☐ Quarterly ☐ Semi-Annual ☐ Monthly Bank Draft |
| Home Health Care Daily Benefit Option (*Coverage Includes $3,500 Lump Sum Caregiver Rider Benefits.)* | ☐ Option A ☐ Option B ☐ Option C Modal Premium $_____ | ☐ Option A ☐ Option B ☐ Option C Modal Premium $_____ |

## Step 2: Choose Optional Benefits

| | Applicant 1 | | | Applicant 2 | | |
|---|---|---|---|---|---|---|
| Ambulance Rider *(Maximum issue age is 80)* | ☐ Modal Premium $_____ | | | ☐ Modal Premium $_____ | | |
| Accident and Sickness Hospitalization Rider* | Option A: | Option B: | Option C: | Option A: | Option B: | Option C: |
| Daily Benefit Amount: *(Choose one)* | ☐ $100 | ☐ $100<br>☐ $200 | ☐ $100<br>☐ $200<br>☐ $300 | ☐ $100 | ☐ $100<br>☐ $200 | ☐ $100<br>☐ $200<br>☐ $300 |
| Benefit Period: *(Choose one)* | ☐ 3 Days<br>☐ 6 Days | ☐ 3 Days<br>☐ 6 Days | ☐ 3 Days<br>☐ 6 Days | ☐ 3 Days<br>☐ 6 Days | ☐ 3 Days<br>☐ 6 Days | ☐ 3 Days<br>☐ 6 Days |
| **(HIP option must follow base option.)* | Modal Premium $_____ | | | Modal Premium $_____ | | |
| Critical Accident Rider | ☐ $5,000 ☐ $10,000<br>Modal Premium $_____ | | | ☐ $5,000 ☐ $10,000<br>Modal Premium $_____ | | |
| Return of Premium Rider | ☐ At death<br>Modal Premium $_____ | | | ☐ At death<br>Modal Premium $_____ | | |

Requested Effective Date: _____/_____/_____

Requested Effective Date cannot be prior to the Application Date. If no Effective Date is requested, the policy will be effective on the date approved by underwriting.

**Premiums**

Applicant 1 Total Premium: $_____

Applicant 2 Total Premium: $_____

*Premiums include an annual $20 Policy Fee*

## Step 3: Pre-Qualification and Medical Information

***If any answer to questions 1-3 is YES (or 1-4 if applying for Option C), do not submit the application.***

| | Applicant 1 | Applicant 2 |
|---|---|---|
| 1. Is the applicant currently (i) living in a nursing home or assisted living facility or (ii) receiving home health care or similar type of care? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 2. Does the applicant require the assistance or supervision of another person or a device of any kind for any one of the following routine Activities of Daily Living (bathing, dressing, eating, continence, toileting or transferring to or from a bed or chair)? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 3. Within the past 12 months has the applicant been diagnosed as having, been prescribed medication for, or received medical advice or treatment from a licensed healthcare professional for Alzheimer's disease, dementia, or memory loss? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **If applying for Option C:**<br>4. In the next 60 calendar days, is the applicant (i) scheduled for or (ii) anticipating the scheduling of:<br>A. Admission to a hospital, nursing home or assisted living facility; or<br>B. Home health care services; or<br>C. Surgery? | ☐ Yes ☐ No | ☐ Yes ☐ No |

## CRITICAL ACCIDENT BENEFIT RIDER

*To be completed if applying for Critical Accident Benefit Rider*

| | Applicant 1 | Applicant 2 |
|---|---|---|
| 1. In the past 3 years has any person participated or intend to participate in flying as a private pilot or crew member, skydiving, parachuting, hang gliding, organized racing (water, land or air), testing cars on a racetrack or speedway, mountain climbing, spelunking, rodeo practice or participation, bungee jumping, in collegiate sports, or participated in any sporting event for pay or prize money? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 2. In the past 3 years has any person had any injuries incurred and resulting from hazardous occupations such as circus worker, commercial fisherman, crop dusters, farm laborers, firefighters, lumberjacks, oil field workers, police, quarry worker, rodeo riders, security guards, underground miners, or window washers? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 3. In the past 12 months has any person been prescribed medication or had surgery or recommended surgery, or undergone therapy for a back, neck or joint disorder? | ☐ Yes ☐ No | ☐ Yes ☐ No |

If YES for 1, 2 or 3 the applicant is not eligible for Critical Accident Benefit Rider.

| Applicant(s) Coverage Information | Applicant 1 | Applicant 2 |
|---|---|---|
| Will any existing supplemental health insurance (including long term care, nursing home, or home health care insurance) be replaced or changed if the proposed coverage is issued? (If "YES," please complete the Replacement Form if required by your state). | ☐ Yes ☐ No | ☐ Yes ☐ No |

If "Yes", for which applicant?
If "Yes", for which Company?

Applicant 1_____

Applicant 2_____

## ACKNOWLEDGEMENTS & AUTHORIZATION

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.

APPLICANT ACKNOWLEDGEMENTS

I hereby apply to United National Life Insurance Company of America ('UNL') for a policy to be issued in reliance on my answers to the questions in this application for insurance coverage ("Application"). I have read or had read to me the completed Application and I represent that all statements made in this Application and all answers to the medical questions contained in the Application are full, complete and true, to the best of my knowledge and belief. I understand that innocent, negligent or fraudulent (i) omissions, (ii) misrepresentations or (iii) misstatements could result in a reduction of benefits or denial of an otherwise valid claim, or rescission of the insurance coverage. I understand that any changes in my health conditions, from the date of this Application until insurance becomes effective, may result in the declination of my coverage. No agent or other representative of UNL has required, permitted, or encouraged me to answer any question inaccurately or waived any conditions of this Application. I acknowledge I have received or will receive the following in conjunction with my Application: (1) the Outline of Coverage, (2) Notice of Privacy Practices, (3) the Pre-Notice which describes how information is obtained and used by UNL, and (3) A Guide to Health Insurance for People with Medicare and the Medicare Duplication of Benefits Disclosure, if eligible for Medicare

Applicant Authorization to Obtain and Disclose Medical Information for Underwriting and Claim Purposes ("Authorization")

I hereby authorize any physician, healthcare professional, hospital, clinic, Veterans Administration or other medical or medical-related facility, pharmacy, pharmacy benefit management company or prescription data base service, insurance carrier, consumer reporting agency, or insurance support organization that has records or knowledge of my past or present health, prescription drug or medication history, other insurance coverage, and criminal or motor vehicle records to give to UNL, and representatives performing services for UNL including its employees, third-party administrators, insurance support organizations, or its reinsurer(s), any such information. This excludes psychotherapy notes. Such information about me may be disclosed to UNL and to any representatives performing services for UNL related to this Application and any policy subsequently issued related thereto ("Policy"). I agree to notify UNL of any change in my health, prescription drug or medications while my Application is in the underwriting process.

I have the right to revoke this Authorization at any time by sending a written request to UNL at 1275 Milwaukee Avenue, Glenview, IL 60025. Attention: Policy Owner Services. I understand revocation of my Authorization will not be effective to the extent UNL has relied on the use or disclosure of my health, prescription drug and/or medication information or so long as UNL has a legal right to contest a claim under the Policy. I understand my Application for insurance can be declined if I choose not to sign this Authorization.

I further understand any protected health information disclosed pursuant to this Authorization, will be protected by UNL in accordance with federal and/or applicable state privacy laws, including but not limited to the Health Insurance Portability and Accountability Act of 1996, as amended.

Electronic Transactions, Electronic Signatures, Policy Fulfillment and Communications

This Application may be completed by electronic device or telephonic means. I acknowledge UNL or the agent has verified my identity in accordance with any applicable federal or state law and that if this Application is completed by electronic means, I have provided my consent and authorization to complete an electronic transaction to apply for this coverage. My electronic signature is legally binding, and has the same effect as if I had physically signed this Application. If this Application is completed by telephonic means, I authorize UNL or its agent to accept my voice signature response as having the same effect as if I had physically signed this Application. I agree that I may receive my Policy and other UNL communications electronically. I also acknowledge receipt of the Electronic Delivery and Communications Disclosure, which describes the requirements for Electronic Policy Fulfillment and Communications, as well as my right to opt-out of Electronic Policy Fulfillment and Communications and receive a paper copy of my Policy free of charge.

Fraud Notice: Any person who knowingly and with intent to defraud an insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, any information or fact thereto commits a fraudulent act, which is a crime and may be reported as such to the appropriate governmental authorities.

Applicant 1 Signature: _____ Date: _____

_____

Signed at: City and State: _____

Applicant 2 Signature: _____ Date: _____

_____

Signed at: City and State: _____

## AGENT'S STATEMENT

I certify that I have accurately recorded the information supplied by the Applicant. I am not aware of any additional information which may have a bearing on the insurability of anyone proposed for insurance on this application and any supplement to it. I have advised the applicant not to withhold any information relative to this application and its questions. I have advised the applicant to review the application for completeness and accuracy and that no coverage is in effect until they are notified in writing by United National Life Insurance Company of America.

| | |
|---|---|
| Agent's Signature, if applicable | Agent's Signature, if applicable |
| Agent's Name (please print) | Agent's Name (please print) |
| Agent Code Commissions Split (if applicable) | Agent Code Commissions Split (if applicable) |
| Agent's E-mail Address | Agent's E-mail Address |

UAPPH2-21-OK (R823)

Monthly Pre-Authorization Premium Payment Plan

Authorization to Honor Withdrawals to be drawn by United National Life Insurance Company of America.

TO _____
Name of my Bank My Bank's Address City State Zip Code

As a convenience to me, I request and authorize you to charge the account shown below for premiums drawn by and payable to the order of United National Life Insurance Company, Glenview, Illinois, provided there are sufficient funds in my account to pay the same upon presentation.

Bank Routing #: _____ Account #: _____

Account Type ○ Checking Account (Attach a Voided "Sample" check)

○ Savings Account (Attach a Voided "Sample" check if applicable, or a Deposit slip)

Draft date: ___/___/___ cannot be more than 15 days from the effective date

I agree that my rights in respect to each payment shall be the same as if it were drawn by me and signed personally by me. This authority is to remain in effect until revoked by me in writing and until you receive notice for which you agree you will be fully protected in honoring such requests. I further agree that if any such payment is not honored, whether with or without cause and whether intentionally, or inadvertently, you shall be under no liability at all although such action could result in the forfeiture of insurance.

| | |
|---|---|
| Printed name of insured if different from premium payer | Premium payer's signature, as it appears on bank records |