Standard Life
AND CASUALTY INSURANCE COMPANY
A ManhattanLife Company

Standard Life and Casualty Insurance Company
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Administrative Office: P.O. Box 510690, Salt Lake City, UT 84151-0690

Application for Home Health Care Indemnity Insurance

APPLICANT INFORMATION

Applicant "A"

Full Legal Name of Proposed Insured _____

Gender: ☐ Male ☐ Female SSN #: ___|___|___ - ___|___ - ___|___|___|___ Date of Birth: _____/_____/_____

Applicant "B"

Full Legal Name of Proposed Insured _____

Gender: ☐ Male ☐ Female SSN #: ___|___|___ - ___|___ - ___|___|___|___ Date of Birth: _____/_____/_____

ADDRESS

Legal Residence Address: _____
Street *City* *State* *Zip*

Mailing Address: _____
Street *City* *State* *Zip*

Applicant "A" Phone No: _____ - _____ - _____	Applicant "B" Phone No: _____ - _____ - _____
Applicant "A" E-mail: _____	Applicant "B" E-mail: _____

PLAN SELECTION

	Applicant "A"	Applicant "B"
Home Health Care Policy	☐ Classic ☐ Premier ☐ Deluxe	☐ Classic ☐ Premier ☐ Deluxe
	Modal Premium $_____	Modal Premium $_____

SELECT YOUR PREMIUM PERIOD *(choose one)* This is the frequency in which you want to pay your premiums.

Applicant "A"

Payment Mode:	☐ Annual	☐ Semi-Annual	☐ Quarterly	☐ Monthly
TOTAL PREMIUM	$_____			
Premiums include an annual $20 Policy Fee				

Applicant "B"

Payment Mode:	☐ Annual	☐ Semi-Annual	☐ Quarterly	☐ Monthly
TOTAL PREMIUM	$_____			
Premiums include an annual $20 Policy Fee				

ELIGIBILITY QUESTIONS

If you are applying for the Home Health Care Indemnity Policy, please answer the following:

	Applicant "A"	Applicant "B"
1. Do you have any health insurance (including home health care, long-term care, or similar coverage) in force at the time of this application?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
2. If the answer to Question 1 is "Yes," do you intend to replace your current health insurance coverage with the policy applied for? (Complete Replacement Notice if "Yes")	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
3. Are you currently living in a nursing home or assisted living facility or currently receiving home health care or similar-type benefits?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
4. Are you physically unable to perform routine activities such as bathing, dressing, eating, toileting or transferring to or from a bed or chair?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
5. Do you acknowledge receipt of an outline of coverage for this policy?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**

AGREEMENTS, AUTHORIZATIONS & SIGNATURES

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE. IT IS REPRESENTED THAT ALL STATEMENTS AND ANSWERS CONTAINED IN THIS APPLICATION ARE FULL, COMPLETE AND CORRECTLY RECORDED AND THAT:

1. This application and any supplements thereto will be the basis for and be a part of any insurance issued, and that all statements and answers in this application and any supplements are complete and true to the best of applicant's knowledge and belief.
2. The insurance applied for in this application will not be considered in force until issued by Standard Life And Casualty Insurance Company (Company) and the first premium paid during the insured's lifetime.
3. The Company shall have 60 days from the date signed in which to consider and act upon this application which the parties agree is a reasonable time. If within such period insurance has not been received by the applicant, or if notice of rejection has not been given, then this application shall be deemed to have been declined by the Company and the Company will return any premium tendered herewith.

I understand that Company, its reinsurers, and their authorized representatives, for purposes of insurability and underwriting determinations, may obtain medical and other information in order to evaluate my application for insurance. The purpose of the release of this information is for the Company to evaluate and underwrite an application for insurance coverage, to determine the rates and terms that apply to such coverage, and/or resolve any issues of incomplete, incorrect, or misrepresented information on the application which may arise during the processing of the application. I authorize any Medical Provider, as described below, to disclose or release Protected Health Information, as described below, to Company and/or their authorized representatives.

- **Medical Provider**: Any physician, medical or dental practitioner, hospital, clinic, pharmacy, pharmacy benefit manager, pharmacy related service organization, or other medical or medically-related facility.
- I also authorize the Veterans Administration, insurance company, MIB, Inc. ("MIB"), my employer, consumer reporting agency, or other organization that possesses information, records, or knowledge of me to furnish such information to Company, its reinsurers, and/or their authorized representatives upon presenting this authorization.
- **Protected Health Information (PHI)**: Any and all records and health information within Medical Provider's possession such as medical history, entire medical records, mental, psychiatric and physical condition, prescription drug records, tobacco, drug and alcohol use and any other PHI concerning me. This includes information which may be considered to be a communicable or sexually transmitted disease.

By my signature below, I acknowledge that any agreements I have made to restrict my PHI do not apply to this authorization and I instruct any Medical Provider to release and disclose my entire medical record without restriction. I authorize the Company or its reinsurers to make a brief report of my PHI to MIB. Company or its reinsurers may make a brief report regarding me to other insurance companies to whom I have applied or may apply. I also understand that information disclosed may be subject to re-disclosure by the recipient in which case it may no longer be protected under the HIPAA Privacy Rule. I, or my authorized representative, am/is entitled to receive a copy of this authorization upon request. This authorization shall remain valid for a period of 24 months from the date hereof. I understand that I may revoke this authorization at any time by mailing written notice thereof to the Company at PO Box 510690, Salt Lake City, UT 84151-0690.

If this application was taken over the telephone, I state that my answers were correctly recorded and I have signed this application after the telephone call.

If accepted by the Company, the applicant(s) request(s) coverage to be effective: ☐ Date of Application ☐ Date of Issue ☐ Other _____/_____/_____ *Effective Date must be between the 1st and the 28th*	**Policy to be Delivered to**: ☐ Applicant(s) ☐ Agent
If eligible for Medicare, I/we have received a "Guide to Health Insurance for People With Medicare" and the "Important Notice to Persons on Medicare".	☐ **Yes** ☐ **No**

AGREEMENTS, AUTHORIZATIONS & SIGNATURES (CONTINUED)

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Applicant "A"

Signed at: _____ _____
City *State*

_____ _____
Signature of Proposed Insured *Date*

_____ _____
Signature of Owner/Trustee (If other than Proposed Insured) *Date*

Owner/Trustee Residence Address: _____
Street *City* *State* *Zip*

Applicant "B"

Signed at: _____ _____
City *State*

_____ _____
Signature of Proposed Insured *Date*

_____ _____
Signature of Owner/Trustee (If other than Proposed Insured) *Date*

Owner/Trustee Residence Address: _____
Street *City* *State* *Zip*

Third-Party Designation of Unintended Lapse

_____ _____
Name of Designee *Address of Designee*

_____ _____
Applicant Signature *Date*

☐ Please check box and sign below if not electing a third-party designation.

_____ _____
Signature *Date*

Agent(s): I certify that I asked each question of the applicant(s) personally and the answers have been truly and accurately recorded hereon.

_____ _____ _____ _____
Signature of Producer/Agent *Producer ID* *Date* *Split %*

_____ _____ _____ _____
Signature of Producer/Agent *Producer ID* *Date* *Split %*

_____ _____
Print Producer Name *Agency Name*

BANK DRAFT AUTHORIZATION

☐ **Automatic Bank Draft (Electronic Funds Transfer)**

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

Type of Account: ☐ Checking ☐ Saving

Desired withdrawal date (Between the 1st and the 28th) _____

☐ 2nd Wednesday ☐ 3rd Wednesday ☐ 4th Wednesday

Bank Name: _____

City: _____ State: _____

Routing number (9 Digits):_____

Account number: _____

The bank draft date selected also becomes the policy effective date as these two dates must match. Additionally, the policy effective date cannot be prior to the applicant's signature date.

Sign the authorization below and provide a voided check or provide the info below from the account you would like to use for bank draft. Your premium will be paid by your bank and will be reflected in your bank statement.

Authorization for Electronic Funds Transfer (EFT)

As a convenience to me, I hereby request and authorize Company to pay and charge to my account checks or credits on my account by and payable to Standard Life And Casualty Insurance Company, Salt Lake City, UT provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that Company's rights in respect to each such check or credit 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 Company actually receives such notice I agree that Company shall be fully protected in honoring any such check or credit. I further agree that if any such check or credit be dishonored, whether with or without cause and whether intentionally or inadvertently, Company shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

_____ _____

Signature EXACTLY as it appears on bank records *Date*

☐ **Bill Me Directly** ☐ Annual ☐ Semi-Annual ☐ Quarterly

If your billing address is different than your home address, please enter it below:

Billing Address: _____

Street *City* *State* *Zip*

Name of person paying, if different: _____

*If paying by check, please make your checks payable to **Standard Life and Casualty Insurance Company**.*