Secure Choice
Application for Short-Term Home Health Care Insurance
Heartland National Life Insurance Company
Administrative Office: PO Box 11903, Winston-Salem, NC 27116
1-888-616-0015

☐ New Business
☐ Reinstatement

Part I – Personal Information

Applicant 1

Last Name | First Name | MI

Birthdate (mm/dd/yyyy) | Social Security Number | Age | Gender ☐ Male ☐ Female

Applicant 1 Phone Number ( ) | E-Mail Address

Beneficiary

Applicant 2

Last Name | First Name | MI

Birthdate (mm/dd/yyyy) | Social Security Number | Age | Gender ☐ Male ☐ Female

Applicant 2 Phone Number ( ) | E-Mail Address

Beneficiary

Physical Address

Street Address

City | State | Zip

Mailing Address (if different than above)

Street Address

City | State | Zip

Part II – Pre-Qualification and Medical Information

If any answer to questions in Part II is YES, do not submit the application.

	Applicant 1	Applicant 2
1. Are you currently receiving assistance or supervision to perform activities of daily living such as bathing, dressing, eating, toileting, getting in or out of bed, or have an inability to control bowel or bladder function?	☐ Yes ☐ No	☐ Yes ☐ No
2. Are you currently receiving home health care services, or confined in a rehabilitation facility, nursing facility or an assisted living facility?	☐ Yes ☐ No	☐ Yes ☐ No
3. Within the past 12 months have you been diagnosed as having, been prescribed medication for or received medical advice or treatment from a licensed health care professional for Alzheimer's disease, dementia or memory loss?	☐ Yes ☐ No	☐ Yes ☐ No
If applying for the Complete Package: 4. In the next 60 days, do you expect to be admitted to a hospital, nursing home/ assisted living facility or require home health care services or have surgery?	☐ Yes ☐ No	☐ Yes ☐ No

Part III – Choose Home Health Care Benefit Option

	Applicant 1	Applicant 2
Short-Term Home Health Care Daily Benefit Option (includes Prescription Drug Benefit)*	☐ Basic ☐ Standard ☐ Complete	☐ Basic ☐ Standard ☐ Complete

Part IV – Choose Optional Benefits

Hospital Confinement Benefit Rider *Must follow Short-Term Home Health Care Daily Benefit Option above	Applicant 1 Basic	Applicant 1 Standard	Applicant 1 Complete	Applicant 2 Basic	Applicant 2 Standard	Applicant 2 Complete
Daily Benefit Amount: (Choose one)	☐ $100	☐ $100 ☐ $200	☐ $100 ☐ $200 ☐ $300	☐ $100	☐ $100 ☐ $200	☐ $100 ☐ $200 ☐ $300
Benefit Period: (Choose one)	☐ 3 Days ☐ 6 Days ☐ 10 Days	☐ 3 Days ☐ 6 Days ☐ 10 Days	☐ 3 Days ☐ 6 Days ☐ 10 Days	☐ 3 Days ☐ 6 Days ☐ 10 Days	☐ 3 Days ☐ 6 Days ☐ 10 Days	☐ 3 Days ☐ 6 Days ☐ 10 Days

Accident and Accidental Death Benefit Rider	☐ $5,000 ☐ $10,000	☐ $5,000 ☐ $10,000
Additional Home Health Aide Coverage Rider	☐ 60 Days	☐ 60 Days
Ambulance Service Benefit Rider	$_____ ($100-$500 in increments of $100)	$_____ ($100-$500 in increments of $100)

Part V – Premium Worksheet

	Applicant 1	Applicant 2
Short-Term Home Health Care Daily Benefit Option (includes Prescription Drug Benefit)	$_____	$_____
Hospital Confinement Benefit Rider	$_____	$_____
Accident and Accidental Death Benefit Rider	$_____	$_____
Additional Home Health Aide Coverage Rider	$_____	$_____
Ambulance Service Benefit Rider	$_____	$_____
Total	$_____	$_____

Part VI – Existing Coverage

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).

Applicant 1: ☐ Yes ☐ No Company: _____

Applicant 2: ☐ Yes ☐ No Company: _____

Part VII – Household Premium Discount Information

You may be eligible for a policy with a lower premium rate based on your answers to the questions in this section.

1. Do you have a household resident (at least one but no more than three): ☐ Yes ☐ No
   a. With whom you have continuously resided for the last 12 months and who is age 18 or older; or
   b. With whom you reside and is your Partner?
2. If you answered "Yes" to question 1 above, please fill out the following information about the household resident:

Name (First, MI, Last): _____

Relation to Applicant: _____

Part VIII – Premium Payment & Administration

REQUESTED EFFECTIVE DATE*:
(if other than Application Date) _____/_____/_____

*The effective date cannot be more than 60 days from the application date.

PAYMENT TYPE: ☐ Bank Draft ☐ Direct Bill Add: Semi-Annual (.520) Quarterly (.265)

PREMIUM MODE: ☐ Monthly Bank Draft ☐ Quarterly ☐ Semi-Annual ☐ Annual

	APPLICANT 1	APPLICANT 2
INITIAL PREMIUM:	**$**_____	**$**_____
POLICY FEE:**	$25.00	$25.00
TOTAL AMOUNT SUBMITTED:	**$**_____	**$**_____

** This one-time fee will be refunded, along with your premium, if the policy is not issued or you return it during your 30-day free look period.

INITIAL PREMIUM:

☐ Draft initial premium immediately ☐ Draft initial premium on (date) _____/_____/_____

SUBSCRIPTION PAYMENTS[***]**:**

Drafted on the ___ day of the month OR the ☐ 2nd ☐ 3rd ☐ 4th Wednesday of the month.

*** Bank drafts can be drawn between the 1st and 28th day of the month. If the subsequent draft date is more than 10 days from the effective date, premiums will be collected a month in advance.

☐ I(we) authorize Bank Draft Payments

If paying by Bank Draft, please include a voided check.

Bank Name: _____

Name(s) of Depositor(s): _____

Bank Routing Number: (first 9 digits) _____ Bank Account Number: (do not include check #) _____

☐ Checking Account ☐ Savings Account

Part IX – Agreement & Acknowledgement

Caution: If your answers on this application are incorrect or untrue, the Company has the right to deny benefits or rescind your policy. This policy provides limited benefits. Review your policy carefully.

I HAVE READ AND FULLY UNDERSTAND the questions and my answers on this Application. To the best of my knowledge and belief they are true and complete.

I UNDERSTAND AND AGREE that: (1) this coverage will be issued based solely and entirely upon my answers to the above questions; (2) no coverage will exist until a policy is issued, and will be in force only as of the policy effective date; (3) any misstatement of fact in this application may result in the denial of benefits or cause the Company to change or rescind my policy; (4) any loss for a pre-existing condition will not be covered for the first 6 months my coverage is in force.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSITUTE 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 major medical health insurance or Medicare that meets the requirements of minimum essential coverage as defined by the federal Affordable Care Act.

I have received an Outline of Coverage. If this application is completed electronically, I understand the Outline of Coverage will be delivered electronically or with the policy. If the application is completed over the phone the Outline of Coverage will be delivered with the policy.

Electronic Transactions, Electronic Signatures, Policy Fulfillment and Communications: This Application may be completed by electronic device or telephonic means. I acknowledge Heartland National 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 Heartland National 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 Heartland National 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.

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim 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 and subjects the person to criminal and civil penalties.

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 Phone: (____) _____

HEARTLAND NATIONAL
Life Insurance Company

PO Box 11903
Winston-Salem, NC 27116

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 disclose 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)

H-HHA17

(Return to Company)

HEARTLAND NATIONAL
Life Insurance Company

PO Box 11903
Winston-Salem, NC 27116

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H-HHA17

(Return to Company)

HEARTLAND NATIONAL
Life Insurance Company

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. Your new policy provides 10 days after receipt of the policy within which you may decide whether you desire to keep the policy. 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) Even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.

(3) 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.\

(4) 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

HEARTLAND NATIONAL
Life Insurance Company

PO Box 11903
Winston-Salem, NC 27116

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Date	Agent Name (Print)
Applicant’s Signature	Agent’s Signature

Leave with Applicant

HEARTLAND NATIONAL
Life Insurance Company

PO Box 11903
Winston-Salem, NC 27116

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of Your expenses, for each day You meet the policy conditions. It does not pay Your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement Insurance.

Medicare generally pays for most or all of these expenses.
Medicare pays extensive benefits for medically necessary services regardless of the reason You need them. These include:

- hospitalization
- physician services
- hospice
- outpatient prescription drugs if You are enrolled in Medicare Part D
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which You may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- Check the coverage in **all** health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Leave with Applicant

HEARTLAND NATIONAL Life Insurance Company

PO Box 11903
Winston-Salem, NC 27116
1-888-616-0015

SECURE CHOICE
SHORT-TERM HOME HEALTH CARE INSURANCE POLICY
OUTLINE OF COVERAGE

Policy 94023 PA
With Optional Rider Form(s) R-23ADSA PA, R-23AS PA, R-23HC PA, R-23HHAC PA

CAUTION: The Policy was issued based on Your answers to the questions on Your application. A copy of Your application will be attached to Your Policy. If Your answers are incorrect or untrue, We may have the right to deny benefits or rescind Your Policy. If, for any reason, any of Your answers are incorrect, contact Us within 30 days at Our Administrative Office: Heartland National, PO Box 11903, Winston-Salem, NC 27116, or call Us, toll free at 1-888-616-0015.

NOTICE TO BUYER

THE POLICY MAY NOT COVER ALL OF THE COSTS ASSOCIATED WITH SHORT-TERM HOME HEALTH CARE INCURRED BY THE BUYER DURING THE PERIOD OF COVERAGE. THIS IS A LIMITED POLICY. THE BUYER IS ADVISED TO REVIEW CAREFULLY ALL POLICY LIMITATIONS AND EXCEPTIONS.

PURPOSE OF OUTLINE OF COVERAGE

This outline of coverage provides a very brief description of some of the important features of Your Policy. This is not the insurance contract and only the actual policy will control the rights and obligations of the parties to it. The policy itself sets forth in detail those rights and obligations applicable to both You and Us. It is very important, therefore, that You **READ YOUR POLICY CAREFULLY**.

GUARANTEED RENEWABLE

Subject to the Maximum Benefit Period, You may keep this Policy in force during Your lifetime by paying the renewal premium at the intervals available to You at the time of renewal. You must pay it by its due date or during the 31-day Grace Period that follows. We cannot cancel or refuse to renew this Policy or place any restrictions on it if You pay Your premiums on time. You may cancel this Policy at any time. In this event, any unearned premium will be returned to You. The Premium rates for the Policy may change, but only if they are changed for all policies like Yours on a class basis. The change may be due to an increase in age, a change in benefits, or a new table of rates. We will provide You with written notice at least thirty (30) days in advance of any change in renewal Premium.

THIRTY-DAY RIGHT TO EXAMINE THE POLICY

If You are not satisfied with the Policy, You may return it to Us within thirty (30) days of its receipt. You may return it to Us by mail or to the agent who sold it. We will refund all Premiums paid and consider the Policy never to have been issued.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

If You are eligible for Medicare, please review "Guide to Health Insurance for People with Medicare" available on request.

NON-PARTICIPATING

SHORT-TERM HOME HEALTH CARE INSURANCE

Policies of this category are designed to provide persons insured with limited or supplemental coverage.

The Policy provides coverage on an indemnity basis for Covered Home Health Care services. All benefits are subject to the definitions, limitations and exclusions described in the Policy.

BENEFIT PROVISIONS

QUALIFYING FOR BENEFITS

Nursing Care Services, Therapy Services and Medical Social Services:

To qualify for benefits, a Licensed Health Care Practitioner must certify You as having a Cognitive or Functional Impairment pursuant to a Plan of Care.

Home Health Aide Services:

To qualify for benefits, a Licensed Health Care Practitioner must certify that You have a Cognitive or Functional Impairment pursuant to a Plan of Care.

We may periodically review the necessity for Covered Home Health Care provided. Our review, for example, may include: (a) diagnosis, symptoms, complaints, and complications of a condition; (b) the reason for the services being rendered; (c) a Licensed Health Care Practitioner's orders; (d) schedule of treatment; (e) physical limitations and impairments; and (f) the objectives of the Licensed Health Care Practitioner's Plan of Care.

LIMITATION ON BENEFITS

Subject to the Qualifying for Benefits provision, We will pay the Daily Benefit Amount as shown in the Benefits Schedule for the applicable Covered Home Health Care provided to You. Benefits paid for Covered Home Health Care are subject to: (a) the Combined Daily Maximum Benefit amount when You receive multiple Covered Home Health Care services in one day; and (b) the allowable Maximum Benefit Period for the applicable Covered Home Health Care service.

We won't pay more than the allowable Maximum Benefit Period days, as shown in the Benefits Schedule.

Covered Home Health Care is incurred on the date the service or treatment is provided. Covered Home Health Care must be incurred while this coverage is in force. When multiple Covered Home Health Care services are received on a single day, We will count only one benefit day toward the Maximum Benefit Period, except when Home Health Aide services are received. In that case, We will count one benefit day toward the Maximum Benefit Period for Home Health Aide services as well as one benefit day for the combined total of all other Covered Home Health Care services received.

COVERED HOME HEALTH CARE

We will pay benefits, as shown on the Benefits Schedule, for the following Covered Home Health Care services when provided by a Home Health Care Agency:

1. Nursing Care Services
    a. Skilled nursing care provided by a registered nurse (RN)
    b. General nursing care provided by a licensed practical nurse (LPN) or licensed vocational nurse (LVN).
2. Therapy Services
    a. Physical Therapy
    b. Speech Pathology
    c. Occupational Therapy
    d. Chemotherapy Specialist
    a. Enterostomal Therapy
    b. Respirational Therapy
3. Medical Social Services
4. Home Health Aide services

PRESCRIPTION DRUG BENEFIT

We will pay the Prescription Drug Benefit when Prescription Drug medication is needed for treating Sickness or Injury incurred while the policy is in force.

Generic / per Prescription Drug	$15
Brand / per Prescription Drug	$30

This benefit is not subject to the Pre-Existing Condition Limitation and is payable without regard to eligibility for Covered Home Health Care benefits. This benefit is subject to the Prescription Drug Policy Year Maximum $360 or $720.

POLICY BENEFITS BY PLAN SELECTION: Listed below are the benefits provided by the Policy. Benefit payment for each Covered Home Health Care service is based upon the plan you select.

COVERED HOME HEALTH CARE SERVICES *(Check applicant's selection)*	PLAN SELECTION		
	Basic	**Standard**	**Complete**
Short-Term Home Health Care Benefits			
Skilled Nursing Care	$100	$200	$300
General Nursing Care	$80	$160	$240
Physical Therapy	$100	$200	$300
Speech Therapy	$100	$200	$300
Occupational Therapy	$100	$200	$300
Enterostomal Therapy	$80	$160	$240
Respirational Therapy	$80	$160	$240
Chemotherapy	$80	$160	$240
Medical Social Services	$120	$240	$360
Combined Daily Maximum Benefit*	**$200**	**$400**	**$600**
Home Health Aide	$50	$100	$150

**Applicable to Nursing Care, Therapy, Chemotherapy Specialist and Medical Social Services*

Prescription Drug Benefit			
Generic / per Prescription Drug	$15	$15	$15
Brand / per Prescription Drug	$30	$30	$30
Prescription Drug Policy Year Maximum	$360	$720	$720

MAXIMUM BENEFIT PERIODS

The Maximum Benefit Period for Home Health Care services, including Nursing Care, Therapy Services, Chemotherapy Specialist Services, and Medical Social Services is 360 days. The Maximum benefit for Home Health Aide services is 120 days.

PRE-EXISTING CONDITIONS LIMITATION

The Policy is subject to a pre-existing condition limitation. Pre-existing conditions are those medical conditions disclosed or not disclosed on the application for which medical advice or treatment was recommended or received from a Doctor within six (6) months prior to the Effective Date of Your coverage.

Any Loss due to a pre-existing condition isn't covered unless the Loss begins more than six (6) months after the Effective Date of Your coverage.

LIMITATIONS AND EXCLUSIONS

The Policy does not provide benefits for Loss as a result of:

1. Due to Injury or Sickness arising out of war or any act of war, declared or undeclared while serving in the military services or any auxiliary unit attached thereto;
2. Due to intentionally self-inflicted Injury;
3. Due to Injury or Sickness arising out of or in the course of employment or which is compensable under any workers' compensation or occupational disease act or law; or motor vehicle no-fault law;
4. For services provided by a member of the Immediate Family unless: (a) he or she is employed by the Covered Home Health Care provider; (b) the Covered Home Health Care provider receives payment for the services; and (c) he or she receives no compensation other than the normal compensation for employees of the Covered Home Health Care provider.
5. For services not included in Your Plan of Care;
6. For services which would not routinely be paid in the absence of insurance;
7. For care received outside the United States or its territories; or
8. For alcoholism, drug addiction, or chemical dependency, unless as a result of a medication prescribed by a Doctor.

HOUSEHOLD PREMIUM DISCOUNT

You are eligible for a Household Premium Discount if for the past year You have resided with at least one, but no more than three, other adults who are age 18 and older. If You live with another adult who is Your Partner, We will waive both the one-year requirement and the age 18 requirement. We may request additional documentation to determine eligibility.

Your Premium will be reduced by the percentage shown on the Policy Schedule. Your Policy's Household Premium Discount will be removed if the other adult no longer resides with You (other than in the case of their death).

OPTIONAL RIDERS

(subject to all terms, conditions, definitions, limitations, exclusions, waiting period and other provisions of each rider)

HOSPITAL CONFINEMENT BENEFIT RIDER – R-23HC

We will pay the Hospital Confinement Benefit of $100-300 per day each day of Hospital Confinement for a covered Accident or Sickness.

Injury: We will pay the Hospital Confinement Benefit for a Loss incurred as a result of a covered Injury. The covered Injury must be initially treated in an Emergency Room or Outpatient Facility within forty-eight (48) hours after the covered Injury occurred with admittance to a Hospital immediately following.

Sickness: We will pay the Hospital Confinement Benefit when You are Hospital Confined for a covered Sickness. Benefit payment is subject to:

1. This Policy and Rider being in force at the time Loss is incurred;
2. Satisfaction of the Waiting Period 0 days; and
3. The Loss not being otherwise excluded from coverage under this Policy and Rider.

Benefits are not payable beyond the Maximum Benefit Period of Hospital Confinement 3, 6, 10 days for any One Period of Hospital Confinement.

Any one continuous period of Hospital Confinement which begins while the Policy with this Rider are in force won't be affected by the termination of the Policy or Rider.

ACCIDENT AND ACCIDENTAL DEATH BENEFIT RIDER – R-23ADSA

Accident Benefit

We will pay benefits, subject to the Maximum Benefit Amount per Accident and the Lifetime Maximum Benefit Amount for Loss You incur as a result of a covered Accident.

Dislocation / Fracture / Knee Ligament/Meniscus Tear Benefit

We will pay benefits, as shown on the Rider Schedule page, when You receive services in an Emergency Room or Urgent Care Facility that are deemed to be Medically Necessary for the treatment of a Dislocation, Fracture or Knee Ligament/Meniscus Tear sustained as a direct result of a covered Accident. Services for the treatment of a Dislocation, Fracture or Knee Ligament/Meniscus Tear must begin within forty-eight (48) hours of a covered Accident.

Benefit Amounts:

Dislocation, hip/knee	25% of Accidental Death Benefit
Fracture, hip or skull	25% of Accidental Death Benefit
Fracture, all other	5% of Accidental Death Benefit
Tear, knee ligament or meniscus	10% of Accidental Death Benefit

If more than one Fracture, Dislocation and /or Knee Ligament/Meniscus Tear is sustained as a result of a covered Injury, only one (1) benefit is payable. The benefit payable will be that of the highest benefit amount associated with the sustained Fracture, Dislocation, or Knee Ligament/Meniscus Tear.

Accidental Death Benefit

We will pay the Accidental Death Benefit of $5,000-$10,000 to the named beneficiary if You should die solely as a result of Injuries sustained in a covered Accident.

ADDITIONAL HOME HEALTH AIDE BENEFIT RIDER – R-23HHAC

We will pay up to an additional sixty (60) days for a Home Health Aide after the Maximum Benefit Period of one-hundred twenty (120) days has been paid.

AMBULANCE SERVICE BENEFIT RIDER – R-23AS

We will pay the Ambulance Service Benefit of $100-$500, if a licensed Ambulance service transports You to or from a medical facility. Benefits payable are limited to one (1) Ambulance service per day, with a maximum of four (4) times per Policy Year. The Ambulance service must be Medically Necessary. We will not pay more than the Lifetime Maximum Benefit of 12 Trips.

POLICY BENEFITS BY PLAN SELECTION: Listed below are the benefits provided by the Policy. Benefit payment for each Covered Home Health Care service is based upon the plan you select.

SHORT-TERM HOME HEALTH CARE DAILY BENEFIT OPTION (INCLUDES PRESCRIPTION DRUG BENEFIT)*	**PLAN SELECTION**		
	☐ Basic	**☐ Standard**	**☐ Complete**
Hospital Confinement Benefit Rider *Must follow Short-Term Home Health Care Daily Benefit Option above	Basic	Standard	Complete
Daily Benefit Amount: (Choose one)	☐ $100	☐ $100 ☐ $200	☐ $100 ☐ $200 ☐ $300
Benefit Period: (Choose one)	☐ 3 Days ☐ 6 Days ☐ 10 Days	☐ 3 Days ☐ 6 Days ☐ 10 Days	☐ 3 Days ☐ 6 Days ☐ 10 Days
Accident and Accidental Death Benefit Rider	☐ $5,000 ☐ $10,000		
Additional Home Health Aide Coverage Rider	☐ 60 days		
Ambulance Service Benefit Rider	$_____ ($100-$500 in increments of $100)		

THIS OUTLINE OF COVERAGE IS A BRIEF SUMMARY OF THE BENEFITS PROVIDED. PLEASE CONSULT THE POLICY TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS. RETAIN THIS OUTLINE OF COVERAGE FOR YOUR RECORDS.

Coverage Description	**Initial Premium**
Short-Term Home Health Care Daily Benefit Option (includes Prescription Drug Benefit) *(Check box for Plan selected)* ☐ **Basic** ☐ **Standard** ☐**Complete**	$_____
Hospital Confinement Benefit Rider	$_____
Accident and Accidental Death Benefit Rider	$_____
Additional Home Health Aide Coverage Rider	$_____
Ambulance Service Benefit Rider	$_____
- Household Discount	7%
+ Application Fee	$25.00
TOTAL PREMIUM	**$**_____