



# Application

Protection Series<sup>SM</sup> –

## **Cancer and Heart Attack or Stroke Plus Insurance Plans**

Policy Form CLICCAN18 VA or CLICCANR18 VA

Policy Form CLICHAS18 VA or CLICHASR18 VA

Underwritten by

**Continental Life Insurance Company  
of Brentwood, Tennessee**

An Aetna Company

**Virginia**

[AetnaSeniorProducts.com](https://AetnaSeniorProducts.com)



**Continental Life  
Insurance Company  
of Brentwood, Tennessee**  
An Aetna Company

P.O. Box 14399  
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# Application for Cancer and Heart Attack or Stroke Plus Insurance Plans

from Continental Life Insurance Company  
of Brentwood, Tennessee

Page 1 of 7

- Print clearly and use blue or black ink.
- Complete all required sections of the application. Any incomplete or missing information could delay processing of your application.

**Please select one:** ☐ New business  
☐ Reinstatement *Policy number* .  
☐ Conversion *Policy number* .

## 1. Proposed insured information

If policy is issued, the proposed insured will become the policy owner.

Write your mailing address if different from your residential address.

Write the birthdate that is on the birth certificate.

Full name of proposed insured <i>First, M.I., Last</i>	Phone	
•	•	
Residential address	Apt/suite number	
•	•	
City	State	Zip
•	•	•
Mailing address	Apt/suite number	
•	•	
City	State	Zip
•	•	•
E-mail	Social Security Number	
•	•	
Birth date <i>mm/dd/yyyy</i>	Age	<input type="radio"/> Male
•	•	<input type="radio"/> Female
Beneficiary name	Relationship	
•	•	

\*Domestic partner means your same sex or opposite sex domestic partner as defined by applicable law.

### Additional proposed insureds

Family members include spouse or domestic partner\* and unmarried child(ren) under age 26.

Full name of spouse <i>please print</i>	Social Security Number	
•	•	
Sex	Birth date <i>mm/dd/yyyy</i>	Age
•	•	•
Full name of child <i>please print</i>		
•		
Sex	Birth date <i>mm/dd/yyyy</i>	Age
•	•	•
Full name of child <i>please print</i>		
•		
Sex	Birth date <i>mm/dd/yyyy</i>	Age
•	•	•
Full name of child <i>please print</i>		
•		
Sex	Birth date <i>mm/dd/yyyy</i>	Age
•	•	•

If additional space is needed. Please use a separate sheet of paper and attach to the application.

### Policy delivery *Select one:*

Agent: ☐ Mail  
Applicant: ☐ Mail ☐ Electronically

**2. Benefits information**

Benefits for Cancer coverage or Heart Attack or Stroke coverage are available in \$100 increments with a minimum of \$5,000 and maximum of \$75,000.

Premium will be drafted upon policy issue.

Requested effective date: • .....

Type of coverage selected:

- ☐ Individual  
☐ Individual and spouse (or domestic partner)  
☐ Individual and child(ren)  
☐ Family

Plan selected:

- ☐ Cancer *or*  
☐ Cancer with recurrence benefit

Benefit amount:

\$.....  
 \$.....

Premium amount:

\$.....  
 \$.....

☐ Heart attack or stroke *or*

\$.....

☐ Heart attack or stroke with recurrence benefit \$.....

Premium mode:

- ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly bank draft (*electronic funds transfer or List Bill only*)

Payment method:

- ☐ Check ☐ Electronic funds transfer ☐ List Bill *Billing file identifier* • .....

Premium collected:

\$.....

**PAYMENT MODES**

You have a choice among several payment options or modes for paying your premium (annual, semi-annual, quarterly and monthly bank draft). Each payment mode, other than annual and monthly bank draft, results in higher total yearly premium costs. Reasons for higher costs include added collection and administrative costs, time value of money considerations and lapse rates.

The annual and monthly bank draft modes have the same total yearly premium costs. As a result, there is a time value of money advantage to you for paying monthly versus annually. However, there may be other advantages to you for choosing an annual payment based on your preferences. Your agent can explain the differences in modes and help you decide which is best for you. You have the right to change your payment mode, among the modes available, during the life of your policy.

**3. Health questions**

COMPLETE THIS SECTION ONLY IF THIS IS AN APPLICATION FOR NEW BUSINESS OR REINSTATEMENT.

If the answer to the question in section A is "yes" the application may be declined.

If any answers to the questions in section B are "yes" then the applicant is not eligible for Cancer coverage.

If any answers to questions in section C are "yes" the applicant is not eligible for Heart Attack or Stroke coverage.

**A. Please answer the following question if you or any other person are applying for coverage.****Have you or any other person applying for coverage:**

1. During the past ten (10) years, been treated for or been diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No

**B. Please answer the following questions if applying for the Cancer benefit.****Within the past five (5) years, have you or any other person applying for coverage under this policy:**

1. Been advised by a Medical Professional to have any tests or monitoring related to cancer, including but not limited to, PSA screenings, mammograms, colonoscopies and genetic screenings, that have not been completed, for which test results have not been received or had abnormal test results where cancer has not been ruled out or results are inconclusive? ☐ Yes ☐ No
2. Experienced any of the following, for which medical advice, diagnosis or treatment has not yet been obtained: unexplained weight loss; a lump, growth or tumor in a breast or elsewhere; or a change in a mole? ☐ Yes ☐ No
3. Diagnosed with or treated for or are currently seeking treatment by a medical professional including surgery, radiation or chemotherapy for leukemia, Hodgkin's Disease, lymphoma, melanoma, sarcoma, myeloma, or any internal cancer? ☐ Yes ☐ No

**Health questions** *continued***C. Please answer the following questions if you or any person are applying for the Heart Attack or Stroke benefit.****Have you or any person applying for coverage:**

1. Within the past 6 months, been treated for, or received medical advice for, or taken prescribed medication for uncontrolled high blood pressure? ☐ Yes ☐ No
2. Within the past 6 months received medical advice or consultation or had medical tests performed (including tests performed during a routine check-up) where the results were other than normal or are still pending? ☐ Yes ☐ No
3. Within the past 5 years, had or been advised to have: any form of heart surgery, or heart related surgery, coronary artery surgery; or angioplasty, pacemaker or defibrillator installed, or arteriogram ? ☐ Yes ☐ No
4. Within the past 5 years, received medical advice for, or ever taken prescribed medications for any disease (excluding high blood pressure), disorder or abnormality of the heart or circulatory system (which includes arteries, veins, lymphatic nodes and vessels)? ☐ Yes ☐ No
5. Within the past 5 years, received medical advice for, or taken prescribed medications for myocardial infarction or heart attack, stroke or transient ischemic attack (TIA)? ☐ Yes ☐ No

**4. Replacement questions**

Do you have any other health insurance in force?			<input type="radio"/> Yes <input type="radio"/> No
Type of coverage	Policy number	Company	
.....	.....	.....	
Type of coverage	Policy number	Company	
.....	.....	.....	
Is the policy being applied for intended to replace any other insurance?			<input type="radio"/> Yes <input type="radio"/> No
Type of coverage	Policy number	Company	
.....	.....	.....	

## 5. Account information

Complete this section if you are requesting electronic funds transfer (EFT) for premium payment.

Include a voided check with the application.

Draft date cannot be on the 29th, 30th or 31st of the month. Requesting to have a draft date more than 15 days greater than the policy's paid to date will draft a month in advance.

This is an example of a personal check. A business check may be different.

For all other checks, use the nine-character bank **routing number**, which appears between the **⑈** symbols, usually at the bottom left corner of the check.

Proposed insured's name

•

Account owner name, if different than proposed insured's

•

Financial institution name

•

☐ Checking ☐ Savings

Routing number

•

Account number

•

Requested EFT draft date

•

John Henry Doe  
PH. 000-000-0000  
1234 Any Street  
Mycity, TN 00000

Date \_\_\_\_\_

Pay to the Order of \_\_\_\_\_ \$ \_\_\_\_\_

Dollars

★ Local Bank  
Mycity, TN

ACH RT 012345678

For \_\_\_\_\_

987654321 12345678 001234

For checks with an **ACH RT (Automated Clearing House Routing) number**, please use this number.

The **account number** is up to 17 characters long and appears next to the **⑈** symbol at the bottom of the check and usually to the right of the bank routing number.

## 6. Electronic funds transfer (EFT) authorization

I understand and accept these terms and conditions:

- We are authorized to withdraw funds periodically from your account to pay insurance premiums for the insured.
- If your financial institution does not honor an EFT request, we will NOT consider your premium paid.
- If your financial institution does not honor an EFT request, we may make a second attempt within five business days.
- We have the right to end EFT payments at any time and bill you directly either quarterly or less frequently for premiums due.
- Information as to each EFT charge will be provided by entry on your account statement or by any other means provided by your financial institution. You will not receive premium notices from us.
- If you want to cancel or change this authorization, you must contact us at least three business days before a scheduled withdrawal.
- Any refund of unearned premium will be made to the policy owner or the policy owner's estate.

Signature only required if the account owner is different than the proposed insured.

Signature of account owner

X

Date

•

**7. Applicant**

I hereby apply to Continental Life Insurance Company of Brentwood, Tennessee for a policy to be issued in reliance on my written answers to the questions on this application. I have read or had read to me the completed application and realize that any false statement or representation in the application may result in the loss of coverage under the policy. I acknowledge that I have received an outline of coverage for the policy applied for, and if 65 years of age or older, *A Guide to Health Insurance for People with Medicare* and a Non-Duplication of Medicare Disclosure.

I agree (1) this application and any policy issued will constitute the entire contract of insurance and the Company will not be bound in any way by any statements, promises or information made or given by or to any agent or other person at any time unless the same is in writing and submitted to the Company at its Home Office and made a part of such contract. Only a Company Officer can make, modify or discharge contracts or waive any of the Company's rights or requirements and then only in writing; and (2) this application shall not be approved until the first premium is paid, there has been no change in my health as stated in the application and a policy has been issued by the Company.

I understand and agree that, if I choose to pay my premium by electronic funds transfer (EFT) from my checking or savings account, the terms and conditions of the EFT authorization in Section 6 of this application are accepted.

**I understand that if any answers on this application are incorrect, incomplete or untrue, Continental Life Insurance Company of Brentwood, Tennessee has the right to reduce my benefits or rescind the policy subject to the time limit on certain defenses provision.**

If accepted for coverage and requesting that the policy be delivered electronically by providing me access on the company's website, I understand and agree (1) to receive this insurance policy and related documents electronically, and (2) that I can obtain a paper copy of my policy at any time by requesting it from the company.

**This policy contains a 30 day waiting period.**

Applicant signature

Date signed

**X**

.

Spouse signature *If applicable*

Date signed

**X**

.

**8. Privacy notice**

Although your application is our initial source of information, we may collect information including health history and medical records from persons other than you, and we may conduct a telephone interview with you. Continental Life Insurance Company of Brentwood, Tennessee, its affiliates, or its reinsurer(s) may also in certain circumstances release information collected by us to third parties without authorization from you. Upon written request, we will provide you with the information contained in your file. Medical information will be disclosed to you only through the medical professional you designate. Should you wish to request correction, amendment or deletion of any information in your file, which you believe inaccurate, please contact us and we will advise you of the necessary procedures. We will provide you a complete notice of insurance information practices upon your written request.

**9. Producer compensation**

When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our Companies, or for the percentage of completed sales. Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

## 10. Agent

All information **must** be completed.

Please list any other medical or health insurance policies sold to the Proposed Insured.

1. List policies sold which are still in force

- .....
- .....

2. List policies sold in the past 5 years which are no longer in force

- .....
- .....

I certify that:

1. I have accurately recorded the information supplied by the applicant.
2. The applicant has read, or had read to him, the completed application and the applicant realizes that any false statement or misrepresentation in the application may result in the loss of coverage under the policy.
3. I have provided an outline of coverage for the policy applied for, and if 65 years of age or older, *A Guide to Health Insurance for People with Medicare* and a Non-Duplication of Medicare Disclosure to applicant prior to completing the application.

The writing number reflects where commissions will be paid.

Agent name *Printed*

Writing number (agent or company)

• .....

Agent signature

State license ID number (for FL only)

**X** • .....

Phone

E-mail

• .....  
• .....

## 11. Agent request to split commissions

This section must be completed with this application in order to split commissions.

If this application results in an issued policy through Continental Life Insurance Company of Brentwood, Tennessee (CLI), the agents listed below have agreed to split the commissions earned on the policy.

- Both agents must be properly licensed and appointed with CLI in the policy's state of issue.
- Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains in force.
- The percentage of the premium split can be for any amount but must be stated in whole numbers and total 100%. (For example, the percentage for the premium split can be from 1% to 99% but cannot be 0% or 100%.)
- Calculation of each agent's commissions are based on their respective CLI commission schedule.

### Agent Information *Print*

Writing Agent

Percentage

• ..... %

Secondary Agent

Writing number

Percentage

• ..... %

Additional Agent

Writing number

Percentage

• ..... %

By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.

Writing Agent Signature

**X** .....

## 12. Fraud warning

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**Virginia:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.





**Continental Life  
Insurance Company  
of Brentwood, Tennessee**

An Aetna Company

P.O. Box 14399  
Lexington, KY 40512-9700

800-264-4000  
AetnaSeniorProducts.com  
office hours 7:00 a.m. - 7:00 p.m. CST

## Initial premium receipt

from Continental Life Insurance Company  
of Brentwood, Tennessee

Page 1 of 1

- Print clearly and use blue or black ink.
- Applicant keeps this receipt for their records.
- Be sure that all required sections of the application are completed. Any incomplete or missing information could delay processing of your application.

### Initial premium receipt

Applicant name <i>Printed</i>	Date of application <i>mm/dd/yyyy</i>
.....	.....
Electronic funds transfer (EFT) draft amount	Initial modal premium collected/drafted
\$ .....	\$ .....
Electronic funds transfer (EFT) draft date	
.....	
This acknowledges receipt of the initial premium in connection with your application for a Continental Life Insurance Company of Brentwood, Tennessee Cancer or Heart Attack or Stroke Plus insurance policy.	
Agent name <i>Printed</i>	Phone
.....	.....
Signature of agent	
<b>X</b> .....	

- Payment will be refunded for any coverage not issued.
- A recorded telephone interview may be necessary as part of the underwriting on your application for insurance.
- All premium payments must be made payable to Continental Life Insurance Company of Brentwood, Tennessee.
- DO NOT make any check payable to the agent and do not leave the payee blank on the check.

A. If this payment equals the full, initial premium for the mode of premium payment selected by the applicant(s); and B. if the answers are true and correct in the application and if Continental Life Insurance Company of Brentwood, Tennessee issues a policy according to its rules, limits, and standards for the plan and amount applied for by the applicant(s); then this payment shall be applied to the payment of the first premium of the issued policy. No policy shall be effective until it has actually been issued by Continental Life Insurance Company of Brentwood, Tennessee.

**Thank you for choosing**

**Continental Life Insurance Company of Brentwood, Tennessee!**