APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE * UNITED AMERICAN INSURANCE COMPANY
A NEBRASKA STOCK COMPANY

PART I: APPLICANT INFORMATION

Plan Code
(Refer to Rate Card)

Effective Date Requested (mm-dd-yyyy)

Mode of Premium
- ○ Annual
- ○ Semi-Annual
- ○ Quarterly
- ○ Monthly

Method of Payment
- ○ Send Premium Notices
- ○ Automatic Payment Plan

Draft Date
Day (01-28) of the Month to Draft Bank Account

Select Plan Applying for
○ A ○ B ○ C* ○ D ○ F* ○ HDF*
○ G ○ HDG ○ K ○ L ○ N

*Applicants first eligible for Medicare before 2020 only

Applicant's First Name

M.I.

Last Name

Applicant's Mailing Address:

Street or Route

City

State

Zip Code

County

If Applicant's Residence Address is different from Mailing Address, show below:

Street or Route

City

State

Zip Code

County

Social Security Number - -

Date of Birth (mm-dd-yyyy) - -

Age Last Birthday

Sex ○ Male ○ Female

E-mail Address of Proposed Insured

Application Verification Information

A recorded interview may be necessary as part of the underwriting of your application for insurance. The most convenient time and place for the interview is:
- ○ 8 AM - Noon
- ○ Noon - 6 PM
- ○ 6 PM - 9 PM

Home Phone No. - -

Work Phone No. - -

Initials of Proposed Insured

PART II: ELIGIBILITY QUESTIONS

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application. **PLEASE ANSWER ALL QUESTIONS**.

TO THE BEST OF YOUR KNOWLEDGE: **Yes No**

1. (a) Did you turn age 65 in the last six (6) months? ○ ○
   (b) Did you enroll in Medicare Part B in the last six (6) months? ○ ○
   (c) If "YES", what is the effective date? (mm-dd-yyyy) ☐☐ - ☐☐ - ☐☐☐☐
   (d) What is your Medicare Claim Number? ☐☐☐☐☐☐☐☐☐☐☐
   (as shown on your Medicare card omitting dashes)

2. Are you covered for medical assistance through the state Medi-Cal program? **Yes No**
   NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question. ○ ○
   If you answered "YES":
   (a) Will Medi-Cal pay your premiums for this Medicare Supplement policy? ○ ○
   (b) Do you receive any benefits from Medi-Cal OTHER THAN payment towards your Medicare Part B premium? ○ ○

3. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END Date" blank.
   START Date (mm-dd-yyyy) ☐☐ - ☐☐ - ☐☐☐☐ END Date (mm-dd-yyyy) ☐☐ - ☐☐ - ☐☐☐☐
   Yes No
   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ○ ○
   (c) Was this your first time in this type of Medicare plan? ○ ○
   (d) Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ○ ○

4. (a) Do you have another Medicare Supplement policy in force? ○ ○
   (b) If so, with what company, and what plan do you have? _____
   (c) If so, do you intend to replace your current Medicare Supplement policy with this policy? ○ ○

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) ○ ○
   (a) If so, with what company and what kind of policy?
   _____
   _____
   _____
   (b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END Date" blank.)
   START Date (mm-dd-yyyy) ☐☐ - ☐☐ - ☐☐☐☐ END Date (mm-dd-yyyy) ☐☐ - ☐☐ - ☐☐☐☐

6. Are you within 6 months of your enrollment in Medicare Part B or otherwise qualified for open enrollment, or are you guaranteed issue as an eligible person (as described in PART VII)? **Yes No** ○ ○
   NOTE: If the answer to Question 6 is "YES," DO NOT complete the Health Questions in Part III.

PART III: HEALTH QUESTIONS

Complete these Health Questions only if you are NOT applying during a guaranteed issue or open enrollment period. Please see PART VII of this application to help you determine if you are applying during a guaranteed issue or open enrollment period.

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES," THE APPLICANT IS NOT ELIGIBLE FOR COVERAGE:

	Yes	No	Unsure
1. What is your height and current weight ? Height (ft. in.) ☐ ☐☐ Weight (lbs.) ☐☐☐			○
2. Are you currently hospitalized, confined to a nursing facility or receiving Medicare approved home health care, or have you been hospitalized or received Medicare approved home health care 2 or more times in the past 12 months?	○	○	○
3. Do you have emphysema, Chronic Obstructive Pulmonary Disease (COPD), or pulmonary fibrosis?	○	○	○
4. Are you bedridden or do you use a wheelchair for any daily activity, or have you been diagnosed with Gaucher's Disease or any other type of lysosomal storage disorder, or have you had any type of amputation caused by disease?	○	○	○
5. Have you been advised that surgery may be required within the next twelve months for cataracts?	○	○	○
6. Have you been diagnosed or treated for Parkinson's disease, Multiple or Lateral Sclerosis, Alzheimer's disease, senile dementia, or organic brain disorder?	○	○	○
7. Have you been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? **California Law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**	○	○	○
8. Do you have diabetes requiring more than 50 units of insulin daily?	○	○	○
9. Within the past 2 years, have you been diagnosed or treated for internal cancer, melanoma, leukemia, alcoholism or drug abuse, cirrhosis, mental or nervous disorder requiring psychiatric care, or have you been advised to have kidney dialysis?	○	○	○
10. Within the past 2 years, have you been diagnosed or treated for heart attack, peripheral vascular disease, congestive heart failure, heart valve disorder, stroke, or transient ischemic attacks (TIA)?	○	○	○
11. Within the past 2 years, have you been diagnosed or treated for rheumatoid arthritis or crippling arthritis?	○	○	○
12. Within the past year, have you been fed intravenously or through a tube, have you been medically advised to have surgery for joint replacement or for a heart condition, but not had such surgery, or have you been advised to have other surgery that has not been performed?	○	○	○
13. Have you used tobacco or nicotine in any form in the past 12 months?	○	○	○

PART IV

I. INVOLUNTARY TERMINATION OF COVERAGE:

If your previous coverage was terminated involuntarily, please provide a copy of the notice of termination of coverage and attach it to this form.

What type of coverage was terminated? _____

Date of termination? (mm-dd-yyyy) ☐☐ - ☐☐ - ☐☐☐☐ Reason for termination? _____

II. VOLUNTARY TERMINATION OF COVERAGE:

If you voluntarily terminated your present coverage, please attach evidence of previous coverage to this form.

What type of coverage was terminated? _____

Date of termination? (mm-dd-yyyy) ☐☐ - ☐☐ - ☐☐☐☐ Reason for termination? _____

If you voluntarily terminated coverage under a Medicare Advantage plan* or Medicare Select policy, please answer the following questions:

	Yes	No
1. Was this the first time you were ever enrolled in a Medicare Advantage plan or purchased a Medicare Select policy?	○	○
If so, did you have the Medicare Advantage plan or Medicare Select policy for less than 12 months?	○	○
2. Did you have a Medicare Supplement policy before applying for the Medicare Advantage plan or Medicare Select policy? If "YES," with which Company and which Medicare Supplement plan? _____	○	○
Is that Company still offering that Medicare Supplement plan?	○	○

* Medicare Advantage plan means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1), and includes: (1) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans; (2) Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and (3) Medicare Advantage private fee-for-service plans.

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PART V: APPLICANT AUTHORIZATION

(1) You do not need more than one Medicare Supplement policy.
(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
(3) You may be eligible for benefits under Medi-Cal and may not need a Medicare Supplement policy.
(4) If, after purchasing this policy, you become eligible for Medi-Cal, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medi-Cal for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal. If you are no longer entitled to Medi-Cal, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Med-Cal eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
(5) If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
(6) Counseling services are available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medi-Cal program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). If you want to discuss buying Medicare Supplement insurance with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

I hereby apply to United American Insurance Company for a policy to be issued in reliance on my written answers to the above questions. The answers are, to the best of my knowledge and belief, true. I agree the policy shall not be effective unless it has actually been issued. I have received an outline of coverage for the policy applied for and a Medicare Supplement Buyers Guide.

I understand that loss due to injury or sickness for which medical advice was received or treatment was recommended or given by a physician within **6 months** prior to the policy effective date is not covered unless the loss is incurred more than **60 days** after the policy effective date, subject to the Time Limit on Certain Defenses provision and legal proceedings. This does not apply to applicants who qualify for open enrollment or guaranteed issue rights.

A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free number (1-800-434-0222), or by accessing the Department of Insurance's Internet Website (www.insurance.ca.gov).

I, HEREBY AUTHORIZE MIB, Inc. ("MIB"), any insurance company, hospital, physician, or other practitioner that possesses any records of me or my physical or mental health and/or treatment, and any pharmacy or any pharmacy benefits manager that possesses prescription history about me, to give any and all such information to United American Insurance Company, or its reinsurers, for the purpose of determining my eligibility for insurance and eligibility for benefits under this policy. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case, it may not be protected under federal privacy rules. I authorize United American Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. This authorization shall be valid for two years from this date and may be revoked by sending written notice to United American Insurance Company at P.O. Box 8080, McKinney, TX 75070. I understand that I may request a copy of this authorization from United American Insurance Company or request a copy of the information in MIB's files by writing to MIB at MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 or calling (866) 692-6901. I acknowledge receipt of the MIB Pre-Notice. A photographic copy of this authorization will be as valid as the original.

No agent may bind, alter, change or waive any underwriting requirements or other provisions of the application or policy. Final acceptance is made by the Underwriting Department of the Company.

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

California Law Prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Application Signed at City | **State** | **On this Date (mm-dd-yyyy)**

Amount paid with application: $, .

for first months premiums.

Total Premium $, .

Applicant's Signature

PART VI: AGENT CERTIFICATION

The undersigned Agent certifies that he/she has ☐/has not ☐personally met with the applicant and that the Applicant has read, or had read to him/her, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy. If the undersigned Agent willfully states as true any material fact(s) that the Agent knows to be false, the Agent shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to $10,000.

AGENT COMPLETES (Attach separate sheet, if necessary.)

1. List any other health insurance policy you have sold to the Applicant which is still in force:

_____

_____

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years which is no longer in force:

_____

_____

I attest that: (1) To the best of my knowledge, the information on the application is complete and accurate, (2) I have given an outline of coverage for the policy applied for and a Medicare Supplement Buyers Guide to the Applicant, (3) I have explained to the Applicant, in easy-to-understand language, the risk to the Applicant of providing inaccurate information and the Applicant understood the explanation.

Last Name | Agent No.

_____
Agent's Signature

MA15(04)R MAIL POLICY TO: ○ Agent ○ Insured (The Policy will be sent to Insured unless otherwise instructed.)

PART VII:

Please read the following for Guaranteed Issue and Open Enrollment Eligibility carefully. During Guaranteed Issue and Open Enrollment periods, we must sell you one of the required Medicare Supplement plans regardless of your health status.

GUARANTEED ISSUE ELIGIBILITY:

The following are the categories of the individuals who are eligible for Guaranteed Issue:

(1) You are enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan either terminates or ceases to provide all of those supplemental health benefits or the employer no longer provides insurance that covers all the payment for the 20 percent coinsurance.

(2) You are enrolled in a Medicare Advantage Organization under a Medicare Advantage Plan under Medicare Part C, and any of the following apply:
   (a) The certification of the organization or plan has been terminated; or
   (b) The organization has terminated or otherwise discontinued providing the plan in the area in which you reside; or
   (c) You are no longer eligible to elect the plan because of a change in the area in which you reside; or
   (d) The Medicare Advantage Plan in which you are enrolled reduces any of its benefits or increases the amount of cost sharing or premium or discontinues, for other than good cause relating to quality of care, its relationship or contract under the plan with a provider who is currently furnishing services to you. You shall be eligible for a Medicare Supplement policy issued by the same issuer through which you were enrolled at the time the reduction, increase, or discontinuance described above occurs, or commencing January 1, 2007, for one issued by a subsidiary of the parent company of that issuer or by a network that contracts with the parent company of that issuer. If no Medicare Supplement policy is available to you from the same issuer, a subsidiary of the parent company of the issuer, or a network that contracts with the parent company of the issuer, you shall be eligible for a Medicare Supplement policy issued by any issuer if the Medicare Advantage Plan in which you are enrolled does any of the following: increases the premium by 15 percent or more, increases physician, hospital, or drug copayments by 15 percent or more, reduces any benefits under the plan, or discontinues, for other than good cause relating to quality of care, its relationship or contract under the plan with a provider who is currently furnishing services to you.
   (e) Enrollment in a Medicare Supplement policy from an issuer unaffiliated with the issuer of the Medicare Advantage Plan in which you are enrolled shall be permitted only during the annual election period for a Medicare Advantage Plan, except where the Medicare Advantage Plan has discontinued its relationship with a provider currently furnishing services to you. Nothing in this section shall be construed to authorize you to enroll in a group Medicare Supplement policy if you do not meet the eligibility requirements for the group.
   (f) You demonstrate, in accordance with guidelines established by the secretary, either of the following:
      i. The organization offering the plan substantially violated a material provision of the organization's contract in relation to you, including the failure to provide on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide the covered care in accordance with applicable quality standards; or
      ii. The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual.

(3) You are 65 years of age or older, enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider, and circumstances exist that would permit discontinuance of your enrollment with the provider if you were enrolled in a Medicare Advantage Plan.

(4) If you meet both of the following conditions:
   (a) You are enrolled with any of the following:
      i. An eligible organization under a contract of the Social Security Act (Medicare cost).
      ii. A similar organization operating under demonstration project authority, effective for periods before April 1, 1999.
      iii. An organization under an agreement of the Social Security Act (health care prepayment plan).
      iv. An organization under a Medicare Select policy.
   (b) Enrollment ceases under the same circumstances that would permit discontinuance of your election of coverage under paragraph (2) or (3) above.

(5) You are enrolled under a Medicare Supplement policy, and enrollment ceases because of any of the following circumstances:
   (a) Insolvency of the issuer or bankruptcy of the non-issuer organization, or other involuntary termination of coverage or enrollment under the policy; or
   (b) The issuer of the policy substantially violated a material provision of the policy; or
   (c) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provision in marketing the policy to you.

(6) If you meet both of the following conditions:
   (a) You were enrolled under a Medicare Supplement policy and terminate enrollment and subsequently enroll, for the first time, with any Medicare Advantage Organization under a Medicare Advantage Plan under Medicare Part C, any eligible organization under a contract of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider of the Social Security Act, or a Medicare Select policy; and
   (b) The subsequent enrollment is terminated by you during any period within the first 12 months of the subsequent enrollment (during which the enrollee is permitted to terminate the subsequent enrollment).

PART VII: (continued)

Please read the following for Guaranteed Issue and Open Enrollment Eligibility carefully. During Guaranteed Issue and Open Enrollment periods, we must sell you one of the required Medicare Supplement plans regardless of your health status.

(7) If upon first becoming eligible for benefits under Medicare Part A at 65 years of age, you enroll in a Medicare Advantage Plan under Medicare Part C or with a PACE provider, and disenroll from the plan or program not later than 12 months after the effective date of enrollment.
(8) While you were enrolled under a Medicare Supplement policy that covers outpatient prescription drugs you enroll in a Medicare Part D plan during the initial enrollment period, terminate enrollment in the Medicare Supplement policy, and submit evidence of enrollment in Medicare Part D along with the application for a policy.

If any of the above categories apply to you, please complete the Application for Medicare Supplement insurance (except for the Health Questions in PART III) and submit evidence of the date of termination or disenrollment. Application must be made for coverage no later than 63 days after termination and disenrollment except for guaranteed issue under paragraph (8) above, in which case application must be made no later than 63 days after the effective date of coverage under Medicare Part D.

OPEN ENROLLMENT ELIGIBILITY:

The following are the categories of the individuals who are eligible for Open Enrollment:
(1) You are entitled to open enrollment if you will be 65 years of age or older on the effective date of the Medicare Supplement plan and if you apply for the plan prior to or during the six-month period beginning with the first day of the first month in which you are enrolled for benefits under Medicare Part B.
(2) You are entitled to open enrollment if you are 64 years of age or younger, enrolled in Medicare by reason of disability, and do not have End-Stage Renal Disease. You must also apply for a plan during the six-month period after the date of your enrollment in Medicare Part B, or the six-month period following notice of eligibility if notified retroactively of your eligibility for Medicare.
(3) If you are enrolled in Medicare Part B, you are entitled to open enrollment for six (6) months following:
   (a) Receipt of notice of termination or, if no notice is received, the effective date of termination from any employee-sponsored health plan, including an employer-sponsored retiree health plan.
   (b) Receipt of a notice of loss of eligibility due to the divorce or death of a spouse/registered domestic partner or, if no notice is received, the effective date of loss of eligibility due to the divorce or death of a spouse/registered domestic partner from any employer-sponsored health plan, including an employer-sponsored retiree health plan.
   (c) Termination of health care services for a military retiree or the retiree's Medicare eligible spouse/registered domestic partner or dependent as a result of a military base closure or loss of access to health care services because the base no longer offers services or because the individual relocates.
(4) You are entitled to open enrollment if you are enrolled in Medicare Part B and were covered under a policy, certificate, or contract providing Medicare Supplement coverage but that coverage is terminated because you established a residence at a location not served by the issuer.
(5) You are entitled to open enrollment if your coverage was terminated by a Medicare Advantage Plan. You may apply for any Medicare Supplement coverage provided by Medicare Supplement issuers and available on a guaranteed basis under state and federal law or regulation.
(6) You are entitled to open enrollment if you are enrolled in Medicare Part B and are notified that, because of an increase in your income or assets, you are no longer eligible for Medi-Cal benefits, or you are only eligible for Medi-Cal with share of cost and you certify at the time of application that you have not met your share of the cost.

ANNUAL OPEN ENROLLMENT ELIGIBILITY:

You shall be entitled to an annual open enrollment period lasting 60 days, commencing with your birthday, during which time you may purchase any Medicare Supplement policy that offers benefits equal to or lesser than those provided by the previous coverage.

UNITED AMERICAN INSURANCE COMPANY OFFICE: P.O. BOX 8080, MCKINNEY, TX 75070-8080

FRAUD WARNING ENDORSEMENT

This Endorsement amends and is made a part of the application to which it is attached. The following fraud warning is being added to, or replacing the existing fraud warning in, your application:

> For your protection, California law requires the following notice regarding false statements and information: **Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.**

In all other respects, the application remains unchanged.

CAFRUA

United American insurance company

Bank Draft Authorization

Draft date cannot be the 29th, 30th, or 31st.

Proposed Insured's Social Security Number

[ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]

Requested Bank Draft Day (dd)

[ ][ ]

Payor's First Name [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

M.I. [ ]

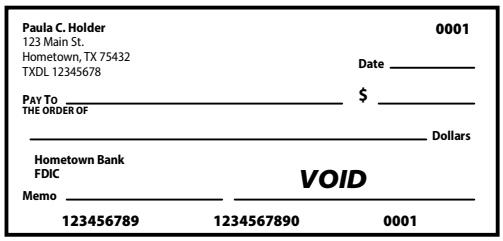
Payor's Last Name [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Bank ABA Routing Number [ ][ ][ ][ ][ ][ ][ ][ ]

Account Number [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Bank Name [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Account information fields above must be complete if voided check is not attached.
See the example check below for the location of the Bank Routing Number and Account Number.



Bank ABA Routing Number

Account Number

Check Number

Helpful Information for Social Security Recipients		
Social Security Benefits Paid On	Birth Date On	Draft Date
Second Wednesday	1st – 10th	14th
Third Wednesday	11th – 20th	21st
Fourth Wednesday	21st – 31st	28th

As a convenience to me, I hereby request and authorize you, United American Insurance Company, McKinney, Texas, to initiate debit entries to my bank account, as recorded above, for insurance premiums and/or non-insurance product fees, as applicable, and the bank named above to debit the same to such account. I agree that your rights and treatment of such debits shall be the same as if they were checks personally signed by me. I further agree that if any such debits are dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, even if such dishonor results in the forfeiture of insurance. This authorization will remain in effect until revoked by me in writing to you, provided that you and the bank shall have a reasonable opportunity to act on such notification. All premiums and/or fees may be automatically withdrawn from my account on MONTHLY mode, unless a different mode has been selected on the application(s).

NOTE - <u>Business</u> accounts are permitted only in relation to sole proprietorships, in which case a voided check and a completed Sole Proprietor form (SP 9-01) are required.

Payor's Signature (as it appears on bank records)

FORM 1080-C

48656

UAI1756 **0423**