Heartland National Life Insurance Company
Administrative Office: PO Box 11903, Winston-Salem, NC 27116
Application- Supplemental Health Insurance

☐ New Business
☐ Coverage Change
☐ Reinstatement

Part I - Personal Information

Applicant 1

Last Name | First Name | MI

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

/ / | - - | | ☐ Male ☐ Female

Street Address

City | State | Zip

Daytime Phone ( ) | Cell Phone ( )

E-Mail Address

Applicant 2

Last Name | First Name | MI

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

/ / | - - | | ☐ Male ☐ Female

Daytime Phone ( ) | Cell Phone ( )

E-Mail Address

Part II - Other Coverage and Replacement Information

1. Is any Applicant covered under a state Medicaid program? ☐ Yes ☐ No

2. Is the coverage applied for replacing any coverage for any Applicant? ☐ Yes ☐ No

If "Yes," please give details below and complete a Replacement Notice.

Company	Applicant Name	Type of Insurance	Policy Number

Part III - Medical Questions

IF YOU ARE WITHIN 6 MONTHS (BEFORE OR AFTER) YOUR 65TH BIRTHDAY, AS OF THIS APPLICATION, DO NOT COMPLETE THIS SECTION.

NOTE: PRE-EXISTING CONDITION LIMITATIONS APPLY WITHOUT REGARD TO ANSWERING QUESTIONS 1-3.

Complete this section by checking "Yes" or "No" for each question. If an answer to any part of the questions 1-3 is "Yes," any individual named will be excluded from coverage under this policy.

Applicant 1 Yes	Applicant 1 No	Applicant 2 Yes	Applicant 2 No	PLEASE ANSWER ALL QUESTIONS
				1. In the past two years have you seen a physician, been diagnosed, treated or taken medication for or been advised to have treatment, surgery or take medication for:
☐	☐	☐	☐	a. Internal cancer, leukemia, melanoma, Hodgkin's disease or lymphoma?
☐	☐	☐	☐	b. Parkinson's disease, Multiple or Amyotrophic Lateral Sclerosis, Alzheimer's disease, dementia or drug or alcohol use?
☐	☐	☐	☐	c. Congestive heart failure, stroke, heart attack, heart disease, cardiomyopathy, aneurysm or peripheral vascular disease?
☐	☐	☐	☐	d. Chronic kidney disease or kidney failure, organ transplant, cirrhosis of the liver or chronic pancreatitis?
☐	☐	☐	☐	e. Complications of diabetes (such as neuropathy, eye or kidney disease) or do you take more than 50 units of insulin per day?
☐	☐	☐	☐	f. Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)?
☐	☐	☐	☐	g. Chronic Obstructive Pulmonary Disease (COPD), emphysema or a condition requiring the use of a CPAP, nebulizer or oxygen?
☐	☐	☐	☐	h. Osteoporosis with related fractures or any connective tissue disorder?
				2. In the past 12 months, have you:
☐	☐	☐	☐	a. Been confined to a nursing facility, bed or wheelchair or received home health care?
☐	☐	☐	☐	b. Been hospitalized 2 or more times or been advised to have surgery that is not yet completed?
☐	☐	☐	☐	c. Used a walker, transcutaneous electrical nerve stimulator (TENS) unit or quad cane?
☐	☐	☐	☐	**3.** Do you have a pacemaker or defibrillator or have you ever had an amputation due to disease?

Part IV - Benefits Selection

Hospital Confinement Indemnity	Applicant 1	Applicant 2
Choose a Daily Benefit Amount ($100 min/$600 max -$50 increments)	$_____ Per Day	$_____ Per Day
Choose Number of Days Payable Per Benefit Period	☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐10 ☐15 ☐ 20 ☐31	☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐10 ☐15 ☐ 20 ☐31
Optional Riders		
1. Lump Sum Hospital Confinement Benefit Rider	☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500	☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500
2. Lump Sum Outpatient Surgery Benefit Rider ($100 min/$1,000 max - $100 increments)	$_____ Lump Sum Amount	$_____ Lump Sum Amount
3. Skilled Nursing Facility Benefit Rider (covered days 21 through 100)	☐ $150 ☐ $ 200	☐ $150 ☐ $200
4. Ambulance Benefit Rider	☐ $200 Per Trip	☐ $200 Per Trip
Premium Worksheet		
Daily Hospital Indemnity Benefit	$_____	$_____
Lump Sum Hospital Confinement Benefit	$_____	$_____
Lump Sum Outpatient Surgery Benefit	$_____	$_____
Skilled Nursing Facility Benefit	$_____	$_____
Ambulance Benefit	$_____	$_____
Total	$_____	$_____

Part V - 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 VI - Premium Payment & Administration

REQUESTED EFFECTIVE DATE:
(if other than 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:	$	$
HOUSEHOLD PREMIUM DISCOUNT	**(-7%)** $	**(-7%)** $
APPLICATION FEE:	$25.00	N/A
TOTAL AMOUNT SUBMITTED:	$	$

The first draft will occur on the date your application is approved by Heartland National Life Insurance Company (unless specified below)

☐ Draft Immediately ☐ Draft Initial Premium on (Date): ____ / ____ / ____

SELECT BANK DRAFT DAY: ____ / ____ / ____ (1st - 28th)

(Must be on or prior to the application effective date)

☐ 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 number) _____

☐ Checking Account ☐ Savings Account

Part VII - Agreement & Acknowledgement

As part of the Application process, Heartland National Life Insurance Company has certain information that you should review as part of your decision to purchase this policy. Please indicate your receipt of this information:

☐ Outline of Coverage ☐ If over age 65, ***A Guide to Health Insurance for People with Medicare***

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.

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines and denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Signed at (City and State): _____ Date: / /

Applicant 1's Signature: _____ Send Policy(ies) to: ☐ Applicant(s)

Applicant 2's Signature: _____ ☐ Producer

Producer's Signature: _____

Producer Number: _____ Producer's Phone: ( )

Part VIII - Producer Supplement

Yes	No		
☐	☐	1.	Did you meet with the Applicant(s) in person?
☐	☐	2.	Did you complete this Application over the phone?
		3.	State the name and relationship of any other person present when this application was taken.

Name: _____ Relationship to Applicant(s): _____

☐	☐	4.	Did you review the Application for correctness and any omissions?
☐	☐	5.	Did the Applicant(s) review the application for correctness and any omissions?
☐	☐	6.	Are you related to Applicant(s)?

If "Yes," provide relationship: _____

☐	☐	7.	Will this policy replace an existing Accident and Health insurance policy? If “Yes”, complete Replacement Notice

Listed below are all other health insurance policies or certificates I have (a) sold to the Applicant(s) which are still in force; and (b) sold to the applicant(s) in the last 5 years which are no longer in force:

Company	Type of Policy	Effective Date	In Force
		/ /	☐ Yes ☐ No
		/ /	☐ Yes ☐ No
		/ /	☐ Yes ☐ No

Producer #1 Name (please print)	Producer Number	Split %
Producer #2 Name (please print)	Producer Number	Split %

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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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

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. 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) 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.

(3) 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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The above “Notice to Applicant” was delivered to me on:

_____	_____
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

OUTLINE OF COVERAGE
LIMITED BENEFIT HEALTH COVERAGE
HOSPITAL INDEMNITY AND RELATED BENEFITS
Policy 93017 CO

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

If You are eligible for Medicare, review the Guide to Health Insurance for People With Medicare available from the company.

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. This is a supplement to health insurance. It is not a substitute for hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance.

PLEASE READ YOUR POLICY CAREFULLY

This Outline of Coverage provides a very brief description of the important features of Your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both You and Your insurance company. It is, therefore, important that You **READ YOUR POLICY CAREFULLY!**

LIMITED BENEFIT HEALTH COVERAGE

Limited Benefit Health Coverage is designed to provide, to persons insured, limited or supplemental coverage. The policy benefits are outlined in Section 4 below; the benefits described in Section 4 may be limited by the limitations contained in Section 6.

BENEFITS PROVIDED UNDER THE POLICY

Hospital Confinement Indemnity Benefit:
We will pay an Insured Person the Hospital Confinement Indemnity Benefit Amount of $100-600 for each day of the Insured Person's Hospital Stay. Benefits are not payable beyond the Maximum Benefit Period of 3-10, 15, 20, 31 days for any Period of Care.

If Your Policy terminates during a Hospital Stay, We will continue to pay this benefit until the earlier of the initial date of discharge from the Hospital (regardless of any Hospital re-admission) or the date the Insured Person reaches the Maximum Benefit Period.

Observation Unit Indemnity Benefit:
We will pay the Observation Unit Indemnity Benefit Amount, or 100% of the Hospital Confinement Indemnity Benefit Amount, for each day an Insured Person receives services in an Observation Unit of a Hospital as a result of a covered loss due to a Sickness or Injury. Benefits are not payable beyond three (3) Observation Unit Benefit Days per Calendar Year. This benefit will not be paid if the Hospital Confinement Indemnity Benefit is paid for the same covered day.

Emergency Room Benefit:
We will pay an Insured Person the Emergency Room Benefit Amount of $150 for services the Insured Person receives in a Hospital Emergency room or Hospital affiliated Emergency care facility due to an Injury or Sickness. Benefit limited to one time per Period of Care. The Emergency Room Benefit Amount is payable up to four (4) times per Calendar Year.

HOUSEHOLD DISCOUNT

You are eligible for a 7% 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.

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).

LIMITATIONS AND EXCLUSIONS

Pre-Existing Conditions - No benefits are payable for any loss that begins within the first six (6) months after the effective date of Your Policy which is caused by a Pre-Existing Condition. A Pre-Existing Condition is a condition for which medical advice was given or treatment was recommended or provided by a Physician within 6 months before the effective date of Your Policy.

This Policy excludes benefits for care or expenses:

1. for treatment, services or supplies which:
   - are not prescribed by a Physician as necessary to treat a Sickness or Injury; or
   - are received without charge or legal obligation to pay; or
   - would not routinely be paid in the absence of insurance; or
   - are received from any member of an Insured Person's Immediate Family; or
   - are received outside the United States; or
   - are incurred while this Policy is not in force.
2. due to mental, nervous, psychotic or psychoneurotic illnesses or disorders.
3. resulting from war or an act of war, whether declared or undeclared, or resulting from service in the armed forces of any country.
4. resulting from committing or attempting to commit an assault or felony or participating in a riot or civil commotion.
5. resulting from an attempted suicide or intentionally self-inflicted Injurywhile the Insured Person is sane.
6. for treatment provided in a U.S. government facility, where there is no charge to the Insured Person.
7. for cosmetic surgery other than:
   - reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or
   - reconstructive surgery because of a congenital disease or anomaly.
8. resulting from being legally intoxicated, as defined by the jurisdiction in which the Injury occurs.
9. resulting from an Insured Person's voluntary use of any drug, narcotic or controlled substance, unless as prescribed by the Insured Person's Physician.
10. pregnancy, unless to due to Complications of Pregnancy.

OPTIONAL BENEFIT RIDERS

There are optional benefit riders offered with Your policy for the payment of an additional premium. If You select any of these benefits, they will be included in Your policy.

Lump Sum Hospital Confinement - R-17LSH
We will pay the $500-2,500 benefit amount when an Insured Person experiences a Hospital Stay after the Effective Date of Your Policy and while this Rider is in force.

This benefit is payable for each Insured Person once per Period of Care, with a maximum of two Hospital Stays per Calendar Year.

Lump Sum Outpatient Surgery - R-17LSO
We will pay the $100-1,000 benefit amount when an Insured Person has a surgical procedure performed by a Physician and such procedure is performed in an Ambulatory Surgical Center or Outpatient Facility of a Hospital after the Effective Date of Your Policy and while this Rider is in force.

Benefits payable for each Insured person are limited to one surgical procedure per day, with a maximum of two surgical procedures per Calendar Year.

We won't pay benefits for:

1. surgical procedures performed in a Physician's office or during a Hospital Stay.
2. surgery for corns, calluses and bunions; deviated nasal septum, including submucous resection and/or other surgical corrections thereof unless due to Injury occurring while coverage is in force.
3. surgery for removal of breast implants. This exclusion shall not apply to the removal of breast implants for the medically necessary treatment of a covered Sickness or Injury, unless the implants were implanted solely for cosmetic purposes and not for surgery performed as reconstruction resulting from a Sickness or Injury.
4. surgery for non-malignant warts, moles (boils) and lesions unless a Physician deems as necessary to treat a Sickness or Injury.
5. surgery for sex transformation or reversal thereof.
6. dental surgery except oral surgery for excision of tumors, growths and cysts of the jaw and mouth and surgery to Sound Natural Teeth made necessary by Injury.
7. surgery for refractive anomalies.

Skilled Nursing Facility - R-17SN
We will pay $150-$200 per day when an Insured Person is confined to a Skilled Nursing Facility due to a covered Sickness or Injury after the Effective Date of Your Policy and while this Rider is in force, subject to the following conditions:

1. admission to the Skilled Nursing Facility immediately follows a Hospital Stay of at least three consecutive days;
2. the Skilled Nursing Care is received on a Covered Day.
3. the Insured Person’s Physician must certify the need for the Skilled Nursing Facility confinement; and
4. the Skilled Nursing Facility confinement is for the same covered Injury or Sickness as the Hospital Stay for which We paid benefits.

Benefits payable for each Insured person subject to a 20 day Elimination Period and are not payable beyond Days 21-100 per Period of Care.

Ambulance - R-17A
We will pay the $200 benefit amount if a licensed surface or air ambulance service transports an Insured Person to or from a Hospital due to Injury or Sickness, after the Effective Date of Your Policy and while this Rider is in force. Any ambulance service must be necessary to protect an Insured Person's health and safety when other reasonable and customary travel methods are not available.

Benefits payable for each Insured person are limited to one ambulance service per day, with a maximum of three (3) ambulance services per Calendar Year. We will not pay more than the Lifetime Maximum Amount of $2,500.

GUARANTEED RENEWABILITY OF THIS POLICY

You have the right to continue Your policy as long as You pay Your premiums when due.

NOTICE OF OUR INFORMATION PRACTICES AND PRIVACY POLICY

With your application for insurance we receive personal information about you. You also authorized us to collect your health information. We keep and protect all such information as confidential and do not disclose it to any other persons, entities or organizations unless authorized by you in writing or as allowed or required by law. “We” or “Our” is defined as Heartland National Life Insurance Company and its Third Party Administrator (TPA), Actuarial Management Resources.

Information We Collect And Receive
Personal information we receive about you comes directly from you, such as your name, address, birth date, Social Security number, telephone number, or e-mail address. Health (medical) information about you comes from you and your health care providers (doctors, clinics, hospitals, laboratories, etc.) based on your written Authorization. We may also review information about you on file with the MIB Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members.

What We Do With This Information
Your personal information is entered in our system to identify you as our customer. Other uses of your personal and health information include underwriting your application for insurance and assisting you in a claim for benefits. Your Heartland agent,as our business associate, may have access to your health information during the underwriting process, as authorized by you, and access to your personal information for assistance with your insurance needs.

Under our established procedures, if upon the consideration of your medical information we determine you do not meet our underwriting guidelines for the issuance of a policy, the medical reason(s) for a declination of coverage may be disclosed to the person or entity (usually your doctor) who maintains your medical information. Your doctor can then discuss with you,through a private consultation, the medical reason(s) for our decision.

How We Protect This Information
Our employees and agents are required to keep your personal and health information confidential. Our intention is to request or access only the minimum amount of information necessary. We maintain all your personal or health information in a secured database, with security and procedural measures in place, in compliance with federal law, to safeguard your protected information and alert us if and when unauthorized access is attempted.

We do not disclose your personal or health information with any nonaffiliated third party (person, entity or organization) without your written permission, unless allowed or required by law. Under no circumstances will any information be disclosed to any nonaffiliated party for marketing purposes, such as telemarketing, direct mail or electronic mail marketing.

How You Can Access This Information
Write to us and request copies of the personal information we have about you in our records. You can also find out who we have disclosed this information to and for what reason. If you believe any personal or health information we have about you is incomplete, inaccurate or incorrect, you have the right to request that we correct or delete it. If your request concerns health information we received from a doctor, hospital or other medical provider, we will refer you to that person or entity. You may,in a private consultation with them, have the necessary corrections made to your health information and sent to us.

The MIB Inc.
Information regarding your insurability will be treated as confidential. Heartland National Life Insurance Company, its TPA, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB,toll free, at 1-866-692-6901 (TTY 1-866-346-3642). If you question the accuracy of information in MIB’s file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB’s information office is: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

Heartland National Life Insurance Company, its TPA, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

If you have any questions about this Notice, we can be contacted at:

Heartland National Life Insurance Company
PO Box 11903, Winston-Salem, NC 27116
ATTN: Privacy Officer
Telephone (toll free): 1-888-616-0015

Leave with Applicant

PREMIUM

We will not change the premium for Your policy during Your first year of coverage. Thereafter, We reserve the right to change premium rates for all policies of the same class. We will notify You at least 31 days before any premium change.

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
Limited Benefit Hospital Indemnity Policy	$_____
Lump Sum Hospital Confinement Benefit Rider	$_____
Lump Sum Outpatient Surgery Benefit Rider	$_____
Skilled Nursing Facility Benefit Rider	$_____
Ambulance Benefit Rider	$_____
Household Discount	7%
Application Fee	$25
TOTAL PREMIUM	$_____