CENTRAL UNITED LIFE INSURANCE COMPANY

10777 Northwest Freeway, Houston, TX 77092

Combination Application Cancer/First Occurrence Benefit/Accident/Critical Illness/Disability

❑ New Application ❑ Reinstatement ❑ Benefit Increase ❑ Additional Dependent Group # _____

APPLICANT'S INFORMATION

Name: (Last, First, Middle Initial)			
Date of Birth:	Height: (Ft.)	Weight: (Lbs.)	Gender: (M or F)
Address: (Street, City, State, ZIP Code)			
Telephone Numbers: (Home, Work, and Cell)			Email Address:
Social Security Number:	Primary Employer Name and Address:		
Type of Business:	Date of Employment with Current Employer:		Number of Hours Worked per Week:
Current Occupation – Describe and give exact duties:			
Beneficiary Name:		Beneficiary Relationship:	
Requested Effective Date:		Mail Policy To: ❑ Agent ❑ Insured ❑ Employer	
Billing Method: ❑ Monthly Bank Draft ❑ Direct Bill ❑ Listbill	Billing Mode: ❑ Monthly (Bank Draft Only) ❑ Quarterly ❑ Semi-Annual ❑ Annual		
Primary Physician's Name:	Primary Physician's Address:	Primary Physician's Telephone Number:	

DEPENDANT'S INFORMATION

Name (Print Full Name)	Social Security Number	Gender (M or F)	Date of Birth	Height	Weight (Lbs.)

COVERAGE APPLIED FOR

				Monthly Premium
CANCER (CP4000)	❑ **Cancer Plan** Plan: ❑ A ❑ B ❑ C ❑ D ❑ E ❑ Individual ❑ One Parent ❑ Two Parent			$ _____
	Optional Riders: ❑ Critical Care Rider ❑ Intensive Care Unit Rider ❑ First Occurrence Rider			$ _____
First Occurrence Benefit (FOB)	❑ **First Occurrence Benefit Policy** Amount $_____ ❑ Individual ❑ One Parent ❑ Two Parent			
	Optional Rider: ❑ Cancer Screening Rider			$ _____
ACCIDENT POLICY (EAP)	**Benefit Amount:** ❑ 1.0 Units ❑ 2.0 Units	**Coverage Applied For:** ❑ Individual ❑ Individual/Spouse ❑ Single Parent ❑ Family ❑ Child(ren) Only	**Optional Rider:** ❑ Disability Rider Occupation: ❑ Type ❑ Type 2 Duration: ❑ 12 months ❑ 24 months Benefit Amount: ❑ 1.0 Units ❑ 2.0 Units *(Rider units may be less than or equal to but not more than the policy units.)*	$ _____

COVERAGE APPLIED FOR (continued)

		Monthly Premium
Disability (CDI)	Monthly Benf. / Elim. Period / Benefit Period / Building Benf. Rider / 50% Benf. Red. Unless % selected here **Occ. Class** ❑ 1 ❑ 2 ❑ 3 **Injury** $ _____ _____ _____ ❑ **Sickness** $ _____ _____ _____ **Optional Riders:** Accidental Death & Dismemberment **Primary Insured** $ _____ **Spouse** $ _____ **Children** $ _____	$ _____
Accident Expense (HPACC13)	**Benefit Amount:** ❑ 1.0 Unit ❑ 2.0 Units **Plan Type:** ❑ Individual ❑ Individual & Spouse ❑ Single Parent ❑ Family **Optional Rider:** Annual Wellness Benefit Rider: Yes ❑ No ❑ **Rider Premium:** $ _____	$ _____

FOR ALL COVERAGES

1. Do all members to be insured reside in the home of the applicant? If **NO,** provide details below . . . . . ❑ Yes ❑ No
2. Within the last 10 years, has any applicant been declined for insurance due to health reasons? If **YES,** provide details below. . . . . ❑ Yes ❑ No
3. Have you or anyone proposed for the coverage been diagnosed or been treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or "AIDS" related conditions, or tested positive for Human Immunodeficiency virus (HIV) or its antibodies? If **YES,** provide details below. . . . . ❑ Yes ❑ No
4. Are all applicants citizens of the U.S.? If **NO,** provide details below . . . . . ❑ Yes ❑ No
5. Are you or your spouse now pregnant? If **YES,** provide details below . . . . . ❑ Yes ❑ No
6. Is the policy intended to replace any other insurance now in force? If **YES,** provide company name, policy number and type of coverage below . . . . . ❑ Yes ❑ No

Provide additional information requested for questions 1- 6 in the space provided below:

_____

_____

CANCER/FIRST OCCURRENCE BENEFIT

1. **Cancer:** To the best of your knowledge and belief is any person to be covered under the terms of this policy now being treated for, or within the last 10 years been treated for or diagnosed with cancer in any form including carcinoma in situ? . . . . . ❑ Yes ❑ No
   If **YES,** then list the name(s) of the person(s) to be excluded from coverage _____
2. **First Occurrence Benefit:** Has any person to be covered under the terms of this policy now have or ever had cancer in any form including carcinoma in situ? . . . . . ❑ Yes ❑ No
3. To the best of your knowledge and belief, has any person to be covered under the terms of this policy now have, or within the last 10 years been treated for or diagnosed with Melanoma, Hodgkin's Disease or Leukemia?. . . . ❑ Yes ❑ No
   If **YES,** then list the name(s) of the person(s) to be excluded from coverage _____
4. To the best of your knowledge and belief, within the last 12 months, has any person to be insured had any elevated or rising PSA or CEA tests; abnormal mammogram, pap smear radiological exam, biopsy or scope procedure; or, received treatment, including those during course of routine checkups, where the results were other than normal or still pending? . . . . . ❑ Yes ❑ No
   If **YES,** then list the name(s) of the person(s) to be excluded from coverage _____
5. **Specified Disease:** To the best of your knowledge, information and belief, has any person to be insured under this policy now being treated for, or within the last 10 years been treated for or diagnosed with Addison's Disease, Amyotrophic Lateral Sclerosis, Diphtheria, Encephalitis, Epilepsy, Legionnaire's Disease, Lupus Erythematosus, Meningitis, Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Niemann-Pick Disease, Osteomyelitis, Poliomyelitis, Reye's Syndrome, Rheumatic Fever, Rocky Mountain Spotted Fever, Sickle Cell Anemia, Tay-Sachs Disease, Tetanus, Toxic Epidermal Necrolysis, Toxic Shock Syndrome, Tuberculosis, Tularemia, Typhoid Fever, Whipple's Disease? . . . . . ❑ Yes ❑ No
   If **YES,** please circle the disease(s) and list the name(s) of the person(s) to be excluded from dread disease coverage
   _____

ACCIDENT/ ACCIDENT EXPENSE

1. Are all persons to be insured to the best of your knowledge and belief in good health and free from physical impairment or abnormality? ❑ Yes ❑ No

2.a. Is any person to be insured engaged in any hazardous sports or activities including, but not limited to, racing, parachuting, rodeo riding, racing motorcycles, mountain climbing, scuba diving, or intend to do so? ❑ Yes ❑ No

2.b. Is any person to be insured a member/participant in collegiate athletics, a semi-professional, or professional sport?. ❑ Yes ❑ No

3a. Have you had a driver's license suspended or revoked within the past 3 years? If **YES,** provide details below . . ❑ Yes ❑ No

_____

3.b. Have you had a DWI or DUI within the past 3 years?.. ❑ Yes ❑ No

3.c. Is any person to be insured currently under treatment or has any person to be insured been under treatment for drug or alcohol abuse in the past 3 years? ❑ Yes ❑ No

4. Will the insurance applied for replace or change any other health, accident, or disability insurance in force on the proposed insured? ❑ Yes ❑ No
If **YES,** give name of Company and type of insurance: _____

_____

DISABILITY

If Guaranteed Issue requirements are met, medical underwriting will be waived.

1. HAS ANY PROPOSED INSURED: In the past 2 years had a driver's license suspended/revoked? ❑ Yes ❑ No

If **YES**, License # _____ State _____

2. HAS ANY PROPOSED INSURED: Consulted a physician, received medical treatment, or been hospitalized or confined during the past 3 years? ❑ Yes ❑ No

3. IS ANY PROPOSED INSURED currently covered or eligible for Medicare? ❑ Yes ❑ No
If **YES,** a "Guide to Health Insurance for People with Medicare" must be given to any proposed Insured age 65 or over.

4. List the amount of any other individual disability insurance currently applied for or in force for the primary insured: $ _____

Authorization to Obtain and Release Information: I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, MIB, Inc. ("MIB"), Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or other organization, institution or person, that has any records or knowledge of me or my health or having any non-medical information concerning me to give Central United Life Insurance Company ("the Company") or its reinsurers, any such information. All information used or disclosed pursuant to authorization may be subject to redisclosure by the recipient and may no longer be protected.

I understand that I am authorizing the Company to receive my health information, prescription drug usage history, and non-medical information. I understand that prescription drug usage may be used to verify the presence of certain medical conditions and that such history will not be used to decline coverage. These medical conditions will be confirmed by a telephone interview prior to being used in the underwriting process. The released information received by the Company will remain protected by federal and/or state regulations.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and, to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with the Company.

I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to the Company will result in the rejection of the insurance policy coverage.

I understand that any additional verbal information that I provide to the Company during any telephone interview must subsequently be presented in writing and attested by me and attached hereto as part of this insurance application.

I understand that I may revoke this authorization at any time by notifying the Company in writing at their Administrative Office: 10777 Northwest Freeway, Houston, Texas 77092. I understand that such revocation will not have any effect on actions the Company took prior to their receiving the revocation notice.

I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under a policy. A photocopy of this authorization will be treated in the same manner as the original.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by the Company, the full first premium has been paid, and the policy has been delivered to the applicant; and, (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing.

I, the undersigned applicant, certify that I have read, or had read to me, the completed application and that I realize that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for Insurance is guilty of a crime and may be subject to fines and confinement.

Signed at _____ this _____ day of _____ 20 _____
City, State

X_____ X _____ X _____

Signature of Primary Insured (Parent if person to be insured is less than 15 years old) | Payor/Owner (if other than Proposed Insured) | Spouse

AGENT'S STATEMENT AND CERTIFICATION

1. If a replacement(s), and if state regulations require it, have you:
   a. Given "Notice to Applicant Regarding Replacement of Accident and Sickness Insurance"? . . . . . ❑ Yes ❑ No
   b. Completed replacements forms, if required in your state? . . . . . ❑ Yes ❑ No
   c. Have you complied with state regulations on disclosure? . . . . . ❑ Yes ❑ No

All information recorded by me on this application is true and accurate to the best of my knowledge.

_____

Agent No. | Soliciting Agent Signature | Date

_____

Printed Agent Name | Agent Phone No. | Agent #% | Agent #%

Remarks or special requests: _____

_____

_____

_____

_____

_____

EMAIL CONSENT AUTHORIZATION

❑ I give my written consent to allow Central United Life Insurance Company (the Company) to communicate with me by email to the address(es) listed below. I confirm that I have authorization to provide consent for email to the email address(es) that I provide below and further agree to indemnify and hold harmless the Company for any action or loss arising from any incorrect or false email address(es) provided below. I acknowledge that, should I desire to revoke this written authorization, I will inform the Company, in writing, of such revocation.

❑ I decline to give consent to the Company to communicate with me by email (do not provide email addresses below).

Primary email address: _____ Secondary email address: _____

Signature: _____ Date: _____

Note: The applicant electing to allow for notices and communications to be sent to the electronic mail address provided by the policyholder should be aware that the insurer rightfully considers this election to be consent by the applicant that all notices may be sent electronically, including notice of non-renewal and notice of cancellation. Therefore, the applicant should be diligent in updating the electronic mail address provided to the insurer in the event that the address should change.

NOTICE: ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO CENTRAL UNITED LIFE INSURANCE COMPANY. DO NOT MAKE THE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

PAYMENT OPTIONS AUTHORIZATION

❑ **Monthly Payroll Deduction (Listbill)**

Assigned list bill number, if known: _____

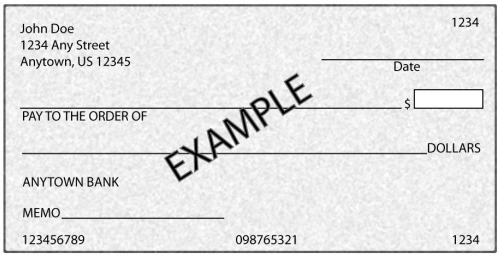
I hereby authorize _____ (Name of Employer) to deduct from my salary and pay to Central United Life Insurance Company the monthly deposits as set forth below.

Beginning with the month of _____, 20 _____

deduct $ _____ each month.

Signature of Employee _____

Date _____



Routing Number Account Number

❑ **Monthly Automatic Bank Draft (Electronic Funds Transfer)**

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

Bank name: _____

City: _____ State: _____

❑ Checking ❑ Savings

If checking account, Routing number (9 Digits): _____

Account number: _____

Authorization for Electronic Funds Transfer (EFT)

I (we) hereby authorize Central United Life Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Account holder's signature: _____ Date: _____

❑ **Credit Card Payment:** ❑ Monthly ❑ Quarterly ❑ Semi-Annual ❑ Annual

Type of Card: ❑ VISA ❑ MasterCard

Credit Card Number _____ Expiration Date _____ CVC Code _____

Name as Shown on Credit Card _____

Accountholder's Signature _____ Date _____

❑ **Bill Me Directly**

❑ Quarterly ❑ Semi-Annual ❑ Annual If your billing address is different than your home address, please enter it below.

Billing Address: _____

(Street) (City) (State) (Zip)

Name of person paying, if different: _____

Notice of Information Practices
Including Fair Credit Reporting Act Notice and MIB, Inc. Notice

Thank you for your application. It is the major source of information about you which we use in evaluating your application and reviewing your policy. However, we wish to inform you that an investigative consumer report may be ordered as to your insurability. If an investigative consumer report is prepared in connection with this application, you may request to be interviewed in connection with the preparation of this report. This report may include, if applicable, information as to your character, general reputation, personal characteristics and mode of living as may be obtained through interviews with family members, friends, neighbors, and associates. If you would like to know whether such a report was ordered and, if so, receive additional information as to its nature and scope, including the name, address and phone number of the reporting agency, we will be pleased to furnish this information upon your written request to our home office at the address below. You may receive a copy of such report by contacting the reporting agency.

Our experience shows that information from investigative reports usually does not have any adverse effect on our underwriting decision. However, if it should, we will notify you in writing of this fact as well as provide you the identity by name and address of the reporting agency. You may then wish to discuss the matter with that agency. We will not disclose information about you without your prior written authorization except as permitted by law. In certain situations we may disclose, as allowed by law, all types of nonpublic personal information as is necessary in order to conduct our business.

This could include disclosures to persons or organizations that will use the information for sales purposes, unless you indicate to us that you do not want the information disclosed for this purpose. You have the right to obtain access to certain items of information we have collected about you, and you have the further right to request correction of information if you feel it is inaccurate. If you wish to have a more detailed description of our information practices, we will be pleased to furnish this information upon your written request to our home office at the address on the front of this Notice.

MIB, Inc. Notice

Information regarding your insurability will be treated as confidential. Central United Life Insurance Company or its reinsurers may, however, make a brief report thereon to 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. 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 about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the 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, Massachusetts 02184-8734. Central United Life Insurance Company, or its reinsurers, may also release information from 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. Information for consumers about MIB may be obtained on its website at www.mib.com. I authorize Central United Life Insurance Company, or its reinsurers, to make a brief report of my protected health information to MIB, Inc.

To obtain further information contact: Central United Life Insurance Company 10777 Northwest Freeway, Houston, Texas 77092