Application for LUMP SUM CANCER *and/or* HEART & STROKE INSURANCE POLICYIES

Heartland National Life Insurance Company
Administrative Office: PO Box 11903, Winston-Salem, NC 27116
1-866-916-7971

☐ New Business
☐ Coverage Change
☐ Reinstatement

Part I – Personal Information

Primary Applicant

Last Name _____ First Name _____ MI ___

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

Daytime Phone _____ Evening Phone _____

Cell Phone _____ E-Mail Address _____

Relationship	Name (First, Middle, Last)	Date of Birth	Social Security Number	Gender
Spouse/Domestic Partner		/ /	- -	
Dependent Child #1		/ /		
Dependent Child #2		/ /		
Dependent Child #3		/ /		
Dependent Child #4		/ /		

Beneficiary Information Please provide beneficiary information for Primary Applicant & Spouse/Domestic Partner if appliable. Primary Applicant will automatically be named the beneficiary for Child(ren) named in the application.

Applicant Name	Name of Beneficiary	Date of Birth	Relationship	Primary or Continent	Percentage of Benefit
		/ /			
		/ /			

Physical Address

Street Address

City _____ State _____ Zip _____

Mailing Address (if different than above)

Street Address

City _____ State _____ Zip _____

Part II – Employment Status (answer only if applying for payroll deduction)

1. Do you work a minimum of twenty(20) hours per week? ☐ Yes ☐ No ☐ Retired

2. If "yes", have you been actively at work for the last thirty (30) days? ☐ Yes ☐ No ☐ Retired

*(If, "No", please explain*_____)

Employer / Job	Title / Duties	Address	Work Location ID *(if applicable)*

Part III – 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 IV – Pre-Qualification and Medical Information

Please complete the following health questions. Coverage is not available for any applicant for whom the answer to any part of Part A, B, C or D. is YES. If the answer is YES to any of the following questions, please explain at the end of Section III. Attach a separate sheet if needed. IF the answer is YES to any question for any Applicant person(s) to be covered, that person will be excluded from coverage as applicable.

Part A - Complete for all Policies* / Riders — **Applicants**

1. Has any Applicant ever been treated or diagnosed by a Medical Professional for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for the Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No

Part B - Complete if applying for Lump Sum Cancer Policy* / Rider

2. Within the past two (2) years:
   a. has any applicant been advised by a Medical Professional to have any tests, treatment 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 inconclusive? ☐ Yes ☐ No
   b. has any applicant experienced any symptoms related to cancer, for which medical advice, diagnosis or treatment has not yet been obtained. Examples include, but are not limited to: unexplained weight loss, a lump, growth or tumor in the breast or elsewhere; or a change in a mole? ☐ Yes ☐ No
3. Within the past five (5) years, has any Applicant been medically diagnosed with or treated for, or are currently seeking treatment by a medical profession for any form of cancer, including, but not limited to leukemia, Hodgkin's Disease, lymphoma, melanoma, sarcoma, myeloma, or any internal cancer? (not including basal or squamous cell skin cancer) ☐ Yes ☐ No

Part C - Please complete if applying for the Heart Attack or Stroke Policy*/ Rider	**Applicants**
Applicant 1: Height *(ft.-in.)* _____ Weight *(lbs.)* _____ **Applicant 2:** Height *(ft.-in.)* _____ Weight *(lbs.)* _____	
4. During the past five (5) years, has any Applicant been advised by a Medical Professional to have any diagnostic testing related to any disease of the heart or circulatory system that has not been completed or for which results have not been received? Or testing results received that were abnormal or inconclusive?	☐ Yes ☐ No
5. During the past five (5) years, has any Applicant consulted with a Medical Professional, or been diagnosed with, treated for, or hospitalized for:	
a. a heart attack or any disease or disorder of the heart or vascular system, a stroke or Transient Ischemic Attack (TIA), or high blood pressure requiring three (3) or more medications to control?	☐ Yes ☐ No
b. Complications of diabetes, diabetic neuropathy, nephropathy, and retinopathy or do you take more than 50 units of insulin per day?	☐ Yes ☐ No
c. Chronic kidney disease (Stages 4 & 5), kidney failure, or kidney disease requiring dialysis.	☐ Yes ☐ No

Part D - Please complete if applying for the Critical Illness Rider	**Applicants**
6. Excluding HIV testing, within the past two (2) years, has any Applicant had any tests for which results were abnormal, inconclusive, or not yet known or been advised to have any medical test, surgery, or other treatment which has not yet been performed?	☐ Yes ☐ No
7. Within the past five (5) years, has any Applicant been diagnosed with, treated for, or consulted with a medical professional for:	
a. emphysema, Chronic Obstructive Pulmonary Disease (COPD), or any other disease or disorder of the lungs (excluding asthma)?	
b. hepatitis (excluding A), cirrhosis, or any other disease or disorder of the liver?	
c. alcohol or drug abuse or dependency?	☐ Yes
d. any disease or disorder of the nervous system including neuromuscular disease, Multiple Sclerosis (MS), Systemic Lupus Erythematosus (SLE), Parkinson's disease, and Amyotrophic Lateral Sclerosis (ALS)?	☐ No
e. aneurysm, blood clot, blood disease or disorder?	
f. pulmonary hypertension, pulmonary fibrosis, tuberculosis, or paralysis?	
g. Alzheimer's disease or dementia?	
8. Has any Applicant ever had:	
a. a defibrillator implanted?	☐ Yes
b. an organ transplant or been advised of the need for a transplant?	☐ No
9. During the past five (5) years, has any Applicant had, been diagnosed with, treated for, or taken medication for any of the following:	
a. aneurysm or pulmonary hypertension?	
b. pulmonary fibrosis or tuberculosis?	
c. paralysis or any disorder of the nervous system including Multiple Sclerosis (MS) or Amyotrophic Lateral Sclerosis (ALS)?	☐ Yes ☐ No
d. glaucoma, retinitis pigmentosa, macular degeneration, optic neuritis, or blindness lasting more than 30 days?	
e. total loss of speech or permanent and total hearing loss in both ears?	
10. Has any Applicant ever had, been diagnosed with, treated for, or taken medication for dementia (including Alzheimer's disease) or any neurological disease or disorder?	☐ Yes ☐ No

*If any answer is Part A is answered "Yes", the application will be Declined. **If any answers to the questions in Part B are "yes" then the applicant is not eligible for Cancer coverage. If any answers to questions in Part C are "yes" the applicant is not eligible for Heart Attack or Stroke coverage. If any answers to questions in Part D are "yes" the applicant is not eligible for the Critical Illness Rider.**

Please record details of all YES answers in Part III *(any Applicant named will be excluded from coverage as applicable)*:

Question #	Applicant Name	Details

Part V – Benefits Selection

Coverage Type: ☐ Individual ☐ Individual & Spouse ☐ One Parent Family ☐ Family

Policy Selection - Select Policy(ies) and any applicable Riders

Cancer Lump Sum Choose Benefit Amount ($5,000 min/$75,000 max –$1,000 increments)	$_____ Benefit Amount
Lump Sum Heart and Stroke Rider ($5,000/$75,000 - $1,000 increments)	$_____ Benefit Amount
Cancer - Return of Premium (select one):	
Payable Upon Death *(max issue age 74)*	☐
Payable Upon Termination (20 years) *(max issue age 74)*	☐
☐ Cancer – Benefit Builder	☐ $500 ☐ $1,000 ☐ $1,500
☐ Radiation, Chemo & Experimental (may only be purchased with Lump Sum Cancer Policy)	☐Essential ☐Enhanced ☐Comprehensive
☐ Critical Illness *(benefit amount must be less or equal to the base policy benefit and cannot exceed $50,000)	$_____ Benefit Amount
Heart & Stroke Lump Sum Choose Benefit Amount ($5,000 min/$75,000 max –$1,000 increments)	$_____ Benefit Amount
Lump Sum Heart and Stroke Rider ($5,000/$75,000 - $1,000 increments)	$_____ Benefit Amount
Heart & Stroke - Return of Premium (select one)	
Payable Upon Death *(max issue age 74)*	☐
Payable Upon Termination (20 years) *(max issue age 74)*	☐
☐ Heart & Stroke – Benefit Builder	☐ $500 ☐ $1,000 ☐ $1,500
☐ Critical Illness *(benefit amount must be less or equal to the base policy benefit and cannot exceed $50,000)	$_____ Benefit Amount

Premium Worksheet

Lump Sum Cancer Policy	$_____
Heart Attack & Stroke Policy	$_____
Lump Sum Cancer Rider	$_____
Lump Sum Heart Attack & Stroke Rider	$_____
Cancer – Benefit Builder Rider	$_____
Heart & Stroke – Benefit Builder Rider	$_____
Cancer – Return of Premium Upon Death Rider	$_____
Cancer – Return of Premium Upon Termination (20 years) Rider	$_____
Heart & Stroke – Return of Premium Upon Death Rider	$_____
Heart & Stroke – Return of Premium Upon Termination (20 years) Rider	$_____
Radiation, Chemo & Experimental Rider	$_____
Critical Illness Rider	$_____
Total	$_____

Part VI – Premium Payment & Administration

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

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

PAYMENT TYPE: ☐ Bank Draft ☐ Direct Bill

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

APPLICANTS

TOTAL AMOUNT SUBMITTED: **$**_____

.

INITIAL PREMIUM:

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

SUBSEQUENT PAYMENTS:**

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

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

☐ I(we) authorize Bank Draft Payments

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

Bank Name: _____

Name(s) of Depositor(s): _____

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

☐ Checking Account ☐ Savings Account

Part 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 twelve (12) 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. Any Applicant who is currently covered by Medicaid is not eligible for this coverage.

WAITING PERIOD: The Lump Sum Heart and Stroke Policy/Rider, Lump Sum Cancer Benefit Builder Rider, Lump Sum Heart and Stroke Benefit Builder Riders, and Radiation, Chemotherapy & Experimental Benefit Rider has have a 30-day Waiting Period which begins on the issue date. No benefits will be paid for any loss that begins during the Waiting Period. WAITING PERIOD means the first 30 days following an Insured Person's issue date.

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

Electronic Transactions, Electronic Signatures, Policy Fulfillment and Communications: This Application may be completed by electronic device or telephonic means. I acknowledge Heartland National or the agent has verified my identity in accordance with any applicable federal or state law and that if this Application is completed by electronic means, I have provided my consent and authorization to complete an electronic transaction to apply for this coverage. My electronic signature is legally binding, and has the same effect as if I had physically signed this Application. If this Application is completed by telephonic means, I authorize Heartland National or its agent to accept my voice signature response as having the same effect as if I had physically signed this Application. I agree that I may receive my Policy and other Heartland National communications electronically. I also acknowledge receipt of the Electronic Delivery and Communications Disclosure, which describes the requirements for Electronic Policy Fulfillment and Communications, as well as my right to opt-out of Electronic Policy Fulfillment and Communications and receive a paper copy of my Policy free of charge.

Any person who, with 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 is guilty of insurance fraud..

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

Applicant 1's Signature: _____

Applicant 2's Signature: _____ Send Policy(ies) to: ☐ Applicant(s) ☐ Producer

Producer's Signature: _____

Producer Number: _____ Producer's Phone: (___) _____

Part VII – Producer Supplement

All questions must be completed.

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 dis- close 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, or an individual named by me, may request to receive a copy of this Authorization. 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)

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

HRN 17

Leave with Applicant

HEARTLAND NATIONAL
Life Insurance Company

I, The Insurance Agent or Broker Certify:

That, I am an insurance agent or broker.

That, I am making the solicitation or sale on behalf of Heartland National Life Insurance Company.

That, I have no connection or affiliation with, and are not in any way sponsored by, the federal or state government, the social security administration, the Centers for Medicare and Medicaid services, or the Department of Health and Human Services.

Agent Name: _____ Phone: _____

Agent Address: _____

Name of Agency: _____ Phone: _____

Agency Address: _____

I, The Applicant understand that I have a right to:

Verify the information above by contacting the Ohio department of insurance;

Ohio Department of Insurance
50 W. Town Street, 3rd Floor-Suite 300
Columbus, OH 43215
(800) 686-1526

Contact the agent or broker making the solicitation or sale at both an address and telephone number provided by the agent or broker;

Contact the insurance company, insurance companies or the insurance company administrative office on behalf of which the solicitation or sale was made at an address and telephone number provided by the agent or broker;

Pay my premium(s) directly to the insurance company's designated administrator, if I purchase a Medicare supplemental insurance policy.

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

I, The Applicant, acknowledge the receipt of this form.

Applicant's Signature _____