Application to United National Life Insurance Company of America for Cancer Shield 2.0 - Cancer Insurance
1275 Milwaukee Avenue Glenview, IL 60025 (800) 207-8050

AGENT NOTE: Please pre-qualify the Applicant(s) with Section III prior to completing the application.

Application for: ☐ New Coverage ☐ Increase of Benefits

If increase requested, please list UNL policy/certificate number(s) affected:_____

SECTION I APPLICANT(S) INFORMATION **SEND DOCUMENTS TO: ☐ AGENT ☐ INSURED**

Applicant 1

Last Name _____ First Name _____ M.I. _____

Social Security # _____ ☐ Male ☐ Female Age _____ Date of Birth _____

Weight _____ lbs. Height _____ ft. _____ in.

Applicant 2

Last Name _____ First Name _____ M.I. _____

Social Security # _____ ☐ Male ☐ Female Age _____ Date of Birth _____

Weight _____ lbs. Height _____ ft. _____ in.

Address *(If Applicant 1 and Applicant 2 have different street addresses, please attach a separate page for Applicant 2.)*

Home Address _____
Street City State Zip

Applicant 1 Email Address_____ Applicant 2 Email Address _____

Applicant 1 Phone Number_____ Applicant 2 Phone Number_____

COMPLETE ONLY IF YOU WISH TO HAVE A SPECIFIC EFFECTIVE DATE
(unless otherwise specified, effective date will be the date the policy is issued)

Requested Effective Date _____/_____/_____ Requested Draft Date _____/_____/_____
Draft day cannot be more than 15 days before or after the effective date.

SECTION II – COVERAGE SELECTION & PREMIUMS				
Premium Payment Mode	☐ **Applicant 1** ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly		☐ **Applicant 2** ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly	
CANCER COVERAGE (U1930)	☐ Option A ☐ Option B ☐ Option C		☐ Option A ☐ Option B ☐ Option C	
Cancer Policy (U1930) *Coverage Includes Rider Benefits for: Chemotherapy/Radiation; Experimental Treatment; Cancer Surgical Procedures; Skin Cancer; Cancer Wellness Screening; Transplant Benefits.*				
Optional Riders *(Select One)* *Plan A Maximum Benefit Amount: $20,000*	☐ *Cancer Lump Sum*	☐ *Cancer, Heart Attack or Stroke Lump Sum*	☐ *Cancer Lump Sum*	☐ *Cancer, Heart Attack or Stroke Lump Sum*
	Benefit Amount $_____ *($1,000-$30,000)*		Benefit Amount $_____ *($1,000-$30,000)*	
Terminal Illness Benefit Rider Choose Terminal Illness Amount *Issue age 40-85*	☐ Option A ☐ Option B ☐ Option C ☐ $100 Daily ($10,000 Max) ☐ $200 Daily ($20,000 Max) ☐ $300 Daily ($30,000 Max)		☐ Option A ☐ Option B ☐ Option C ☐ $100 Daily ($10,000 Max) ☐ $200 Daily ($20,000 Max) ☐ $300 Daily ($30,000 Max)	

Return of Premium Benefit Rider	☐ ROP at Death ROP Factor _____	☐ ROP at Death ROP Factor _____
Complete only if choosing the Return of Premium Benefit Rider	Beneficiary's Full Name _____ Relationship_____	Beneficiary's Full Name _____ Relationship_____

Total Modal Premium ***(Includes modalized $20 Annual Policy Fee)***	**$_____**	**$_____**

SECTION III – HEALTH QUESTIONS	APPLICANT 1	APPLICANT 2
1. For Questions 1a to 1f, in the past 10 years has any person to be insured had, been diagnosed as having, received medication for or been treated by a medical professional for:		
a. Any internal cancer, leukemia, Hodgkin's or Non-Hodgkin's disease, lymphoma, malignant melanoma, sarcoma, or a pre-leukemic or pre- malignant condition?	☐ Yes ☐ No	☐ Yes ☐ No
b. PSA reading greater than 4.0 or abnormal mammogram test result where cancer has not been ruled out for either condition?	☐ Yes ☐ No	☐ Yes ☐ No
c. Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)?	☐ Yes ☐ No	☐ Yes ☐ No
d. Amyotrophic Lateral Sclerosis (ALS), liver, pancreatic or kidney disease, respiratory failure, or congestive heart failure?	☐ Yes ☐ No	☐ Yes ☐ No
e. Alzheimer's disease, dementia, memory loss, Multiple Sclerosis, or Parkinson's disease?	☐ Yes ☐ No	☐ Yes ☐ No
f. Substance Abuse disorder (alcohol or drug) or an organ transplant or been recommended to have an organ transplant?	☐ Yes ☐ No	☐ Yes ☐ No
2. In the past 10 years has any person to be insured required or received oxygen therapy or taken 2 or more medications to treat the following conditions: Chronic Obstructive Pulmonary/Lung Disease (COPD/COLD), Emphysema or Chronic Bronchitis?	☐ Yes ☐ No	☐ Yes ☐ No
If YES for 1a through 1f and/or 2, that person is not eligible for any coverage.		
HEART ATTACK/STROKE BENEFIT RIDER *(Only complete if applying for this rider)*		
3. a. In the past 10 years, has any person to be insured, had, been diagnosed as having, received medication for or been treated by a medical professional for: Heart attack, heart bypass, angioplasty, stent placement, coronary heart disease angina, congestive heart disease, pacemaker or defibrillator placement, heart arrhythmia, peripheral or carotid artery disease, aortic valve disease, stroke, or Transient Ischemic Attack(TIA)?	☐ Yes ☐ No	☐ Yes ☐ No
b. In the past 6 months, has any person to be insured had a blood pressure reading greater than 150 systolic or 95 diastolic?	☐ Yes ☐ No	☐ Yes ☐ No
If YES for 3a or 3b, that person is not eligible for Heart Attack/Stroke Benefit Rider		
TERMINAL ILLNESS BENEFIT RIDER *(Only complete if applying for this rider)*		
4. a. In the past 12 months, has any person to be insured been diagnosed by a member of the medical profession with a terminal illness or other terminal condition and told by a member of the medical profession that they have less than 6 months to live?	☐ Yes ☐ No	☐ Yes ☐ No
b. In the past 12 months, has any person to be insured been diagnosed and told by a medical professional that they have an end-stage medical condition with less than 24 months to live?	☐ Yes ☐ No	☐ Yes ☐ No
If YES for 4a or 4b, that person is not eligible for Terminal Illness Benefit Rider		
ALL APPLICANTS MUST ANSWER #5		
5. For any of the medical conditions listed above, within the past 24 months, has any person to be insured: a. been advised by a medical professional that a diagnostic test was needed, but such diagnostic test has not yet been performed; or b. awaiting the test results of diagnostic test; or c. had a symptom or abnormality that would cause a person to seek medical attention or advice for but has not yet done so?	☐ Yes ☐ No	☐ Yes ☐ No
If YES, that person is not eligible for any coverage.		

SECTION IV – REPLACEMENT OF EXISTING COVERAGE	APPLICANT 1	APPLICANT 2
1. Will any existing specified disease or other accident and health insurance be replaced or changed if the proposed coverage is issued? (If "YES," please complete the Replacement Form, if required in your state.) *If "YES*," with which company? (Applicant 1) _____ *If "YES*," with which company? (Applicant 2) _____	☐ Yes ☐ No	☐ Yes ☐ No

AGENT'S STATEMENT

I certify that I have accurately recorded the information supplied by the Applicant. I am not aware of any additional information which may have a bearing on the insurability of anyone proposed for insurance on this application and any supplement to it. I have advised the applicant not to withhold any information relative to this application and its questions. I have advised the applicant to review the application for completeness and accuracy and that no coverage is in effect until they are notified in writing by United National Life Insurance Company of America.

Signature of Soliciting Agent		Signature of Secondary Agent	
Print Agents Name	Agent Code	Print Agents Name	Agent Code
Agents Email Address		Agents Email Address	

ACKNOWLEDGEMENTS & AUTHORIZATION TO RELEASE MEDICAL INFORMATION

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Acknowledgements

I hereby apply to United National Life Insurance Company of America ('UNL') for a policy to be issued in reliance on my answers to the questions in this application for insurance coverage ("Application"). I have read or had read to me the completed Application and I represent that all statements made in this Application and all answers to the medical questions contained in the Application are full, complete and true, to the best of my knowledge and belief. I understand that innocent, negligent or fraudulent (i) omissions, (ii) misrepresentations or (iii) misstatements could result in a reduction of benefits or denial of an otherwise valid claim, or rescission of the insurance coverage. I understand that any changes in my health conditions, from the date of this Application until insurance becomes effective, may result in the declination of my coverage. No agent or other representative of UNL has required, permitted, or encouraged me to answer any question inaccurately or waived any conditions of this Application. I acknowledge I have received or will receive the following in conjunction with my Application: (1) the Outline of Coverage, (2) Notice of Privacy Practices, (3) the Pre-Notice which describes how information is obtained and used by UNL and (4) A Guide to Health Insurance for People with Medicare and the Medicare Duplication of Benefits Disclosure, if eligible for Medicare.

Authorization to Obtain and Disclose Medical Information for Underwriting and Claim Purposes ("Authorization")

I hereby authorize any physician, healthcare professional, hospital, clinic, Veterans Administration or other medical or medical-related facility, pharmacy, pharmacy benefit management company or prescription data base service, insurance carrier, consumer reporting agency, or insurance support organization that has records or knowledge of my past or present health, prescription drug or medication history, other insurance coverage, and criminal or motor vehicle records to give to UNL, and representatives performing services for UNL including its employees, third-party administrators, insurance support organizations, or its reinsurer(s), any such information. This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. This Authorization excludes psychotherapy notes. Such information about me may be disclosed to UNL and to any representatives performing services for UNL related to this Application and any policy subsequently issued related thereto ("Policy"). I agree to notify UNL of any change in my health, prescription drug or medications while my Application is in the underwriting process.

I also understand UNL, or its authorized representatives, may conduct a phone interview or face-to face assessment with any applicant as part of the underwriting process. Such health, prescription drug and/or medication information will be used to consider my insurability with UNL. I agree and understand this Authorization will be valid for twenty-four (24) months from the date signed below and I, or my authorized representative (if applicable), are entitled to a copy of it. I agree this Authorization may also be used to obtain health, prescription drug and/or medication information or records, as stated above, in order to process a claim that is submitted within the timeframe this Authorization remains valid.

I have the right to revoke this Authorization at any time by sending a written request to UNL at 1275 Milwaukee Avenue, Glenview, IL 60025, Attention: Policy Owner Services. I understand revocation of my Authorization will not be effective to the extent UNL has relied on the use or disclosure of my health, prescription drug and/or medication information or so long as UNL has a legal right to contest a claim under the Policy. I understand my Application for insurance can be declined if I choose not to sign this Authorization.

I further understand any protected health information disclosed pursuant to this Authorization, will be protected by UNL in accordance with federal and/or applicable state privacy laws, including but not limited to the Health Insurance Portability and Accountability Act of 1996, as amended. However, I further understand that if a person or entity who receives this information is not covered by federal privacy regulations, the information may be re- disclosed by such person or entity and will likely no longer be protected by the federal privacy regulation.

Authorization Concerning Medical Information Obtained From and / or Reported to MIB, Inc.. for Underwriting Purposes
I hereby authorize UNL, its authorized representatives and its reinsurers to obtain health, prescription drug, or medication history information from MIB, Inc. and acknowledge that UNL, its authorized representatives and/or its reinsurers, may make a brief report of my medical history, prescription drug or medication history including information about any alcohol and/or drug use disorder or mental illness to MIB, Inc..

Electronic Transactions, Electronic Signatures, Policy Fulfillment and Communications
This Application may be completed by electronic device or telephonic means. I acknowledge UNL or its 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 UNL 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 UNL 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.

Fraud Notice: Any person who knowingly and with intent to defraud an insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, any information or fact material thereto commits a fraudulent act, which is a crime and may be reported as such to the appropriate governmental authorities.

Applicant 1 Signature: _____Date:_____

Applicant 2 Signature: (if applicable) _____Date:_____

Signed at: City and State:_____

Applicant 1 Legal Address: City_____ State: _____ Zip:_____

Applicant 2 Legal Address: City_____ State: _____ Zip:_____

MONTHLY PRE-AUTHORIZED PREMIUM PAYMENT PLAN

Authorization to Honor Withdrawals to be drawn by United National Life Insurance Company of America.

TO _____

Name of my Bank | My Bank's Address | City | State | Zip Code

As a convenience to me, I request and authorize you to charge the account shown below for premiums drawn by and payable to the order of United National Life Insurance Company of America, Glenview, Illinois provided there are sufficient funds in my account to pay the same upon presentation.

Account # _____ Bank Routing # _____

Account Type: ☐ Checking Account *(Attach a Voided "Sample" check)*

☐ Savings Account *(Attach a Voided "Sample" check if applicable, or a Deposit slip)*

I agree that my rights in respect to each payment shall be the same as if it were drawn by me and signed personally by me. This authority is to remain in effect until revoked by me in writing and until you receive notice for which you agree you will be fully protected in honoring such requests. I agree that if any such payment is not honored, whether with or without cause and whether intentionally, or inadvertently, you shall be under no liability at all although such action could result in the forfeiture of insurance.

_____ _____

Printed name(s) of insured(s) if different from premium payer | Premium payer's signature, as it appears on bank records

Detach Here

RECEIPT **DATE**_____

Received of _____ the sum of $_____ and application for insurance to United National Life Insurance Company of America. If for any reason the application is declined this payment will be refunded. No liability is created or assumed by the company, except for refund of this payment, until the insurance applied for has been issued.

Agent's Signature :_____

If you do not receive your policy/certificate within 60 days from the date of your application, please write to:
United National Life Insurance Company of America, 1275 Milwaukee Avenue Glenview, IL 60025

MAKE CHECK PAYABLE TO: UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA