

# **Standard Life and Casualty Insurance Company** Home Office: Salt Lake City, UT

Administrative Office: 10777 Northwest Freeway, Houston, TX

(800) 669-9030

### APPLICATION FOR HOME HEALTH CARE INSURANCE

Reinstatement Benefit increase Policy No Group No					•		
APF	PLICANT A – PROPOSED INSURED'S INI	FORMATION					
Pro	posed Insured's Name (First, Middle, Last)			Birthdate (MM/DD/YYYY)	Gender (M/F	-)	
Add	ress (Street, City, State, ZIP Code)						
Telephone Numbers (Home, Work, and Cell)				Social Security No.			
Beneficiary Name				Requested Future Effective Date *Effective Date will be the date the application is approved by the Company or a future date, whichever is later.			
Ben	eficiary Relationship			Mail Policy to: ☐ Agent ☐ Policyowner ☐ Email (Email is available for the Policyowner if the email consent authorization is signed.)			
AP	PLICANT A - INSURANCE REQUESTED					PREMIUM	
	e Health Care Insurance Policy	☐ Classic - \$150	☐ Premi	er - \$300 🔲 Deluxe - \$4	50 \$		
Rou	tine Annual Examination Rider				\$		
Accidental Death & Dismemberment Rider				\$			
Home Health Equipment Rider				\$			
Accident Expense Benefit Rider		Per Accident - ☐ \$1250 ☐ \$2500		\$	\$		
Ambulance Benefit Rider			\$		- <u></u>		
Pr				APPLICANT A - TOTAL PREMIUM  emium includes an annual \$20 policy fee			
AP	PLICANT A - HEALTH QUESTIONS						
1.						☐ Yes ☐ No	
2.			athing, dres	sing, eating, toileting and tra	nsferring	☐ Yes ☐ No	
AP	PLICANT A – EXISTING COVERAGE						
1.	Do you have existing health coverage (inc	cluding home health ca	are, lona-ter	m care, or similar coverage)?		☐ Yes ☐ No	
2.	Are any policy(s) intended to replace any number, and type of coverage below.		. •			☐ Yes ☐ No	

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APP	LICANT B – PROPOSED INSURED'S INF	ORMATION						
Proposed Insured's Name (First, Middle, Last)				Birthdate (	MM/DD/YYYY)	Gender (M/F	)	
Add	ress (Street, City, State, ZIP Code)							
-				Io :	*( A)			
Telephone Numbers (Home, Work, and Cell)				Social Security No.				
Beneficiary Name					Requested Future Effective Date			
beneficiary Name				*Effective Date will be the date the application is approved by				
					ny or a future date			
Ben	eficiary Relationship			Mail Policy to: ☐ Agent ☐ Policyowner				
				☐ Email (Email is available for the Policyowner if the email consent authorization is signed.)				
AP	PLICANT B - INSURANCE REQUESTED						PREMIUM	
Hom	e Health Care Insurance Policy	☐ Classic - \$150	☐ Prem	ier - \$300	☐ Deluxe - \$4	50 \$		
Rou	tine Annual Examination Rider					\$		
Acci	dental Death & Dismemberment Rider					\$		
Home Health Equipment Rider		<b>□</b> \$ _						
Acci	dent Expense Benefit Rider	Per Accident - □ \$1250 □ \$2500			\$			
Ambulance Benefit Rider						\$		
			_		ANT B - TOTAL			
			Pre	emium includ	les an annual \$20	policy fee *		
AP	PLICANT B - HEALTH QUESTIONS							
1.	Are you currently living in a nursing home or assisted living facility or currently receiving home health care or similar-						5 V 5 V	
2	<ul><li>type benefits?</li><li>Are you physically unable to perform routine activities such as bathing, dressing, eating, toileting and transferring</li></ul>						☐ Yes ☐ No	
from bed to chair?			, tonoung and trai		☐ Yes ☐ No			
AP	PLICANT B – EXISTING COVERAGE							
1.	Do you have existing health coverage (inc				- , , , , , , , , , , , , , , , , , , ,		☐ Yes ☐ No	
2.	Are any policy(s) intended to replace any number, and type of coverage below.	other insurance not in	force? If "Y	es," provide	the company nai	me, policy	☐ Yes ☐ No	
	, ,,							

### **AUTHORIZATION AND SIGNATURE**

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, MIB, LLC (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 to the Standard Life and Casualty Insurance Company (the Company) or its reinsurers, any such information. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal law governing privacy and confidentiality. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.

I authorize Standard Life and Casualty Insurance Company, or its reinsurers, to make a brief report of my protected health information to MIB, LLC.

I understand that I am authorizing the Company to receive my health information, prescription drug usage history and my 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 I may revoke this authorization at any time by notifying the Company in writing at their Administrative Office: 10777 Northwest Freeway, Houston, TX 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 as valid 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.

### THE EFFECTIVE DATE OF THE POLICY WILL BE THE DATE RECORDED BY THE ADMINISTRATIVE OFFICE. IT IS NOT THE DATE THIS APPLICATION IS SIGNED.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony..

Χ	ture of Agent	idersigned 	Printed Agent's Name		Agent No.	% Credit	t involved at this time.  State ID No.
Χ							_%
X	J STATEMENT. I, the un	idersigned	agent, also certify that	to the best of	my knowledge, replac		t involved at this time. _%
A CENT/C	CTATEMENT: L the ur	doreignod	agent also certify that	to the best of	mu knowlodao roplos	oment Die Die nei	
Signed at, on			(Month/Day/Year)	Applicant B's signature (or their authorized representative)			
	(City and State)		(Month/Day/Year)	Applicant A	's signature (or their a	authorized representa	itive)
Signed at		, on _	<i>&gt;</i>	X			

NOTICE: All premium checks must be made payable to Standard Life and Casualty Insurance Company. Do not make the check payable to the agent or leave the payee blank.

APPLICANT A - EMAIL CONSENT AUTHORIZATION
I give my written consent to allow Standard Life and Casualty 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(s) 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:
<b>Note:</b> 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.
APPLICANT B - EMAIL CONSENT AUTHORIZATION
I give my written consent to allow Standard Life and Casualty 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(s) 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 undating the electronic mail address provided to the insurer in the event

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.

APPLICANT A - PAYMENT OPTIONS AUTHORIZATION						
□ Payroll Deduction (Listbill)						
Assigned list bill number, if known:		1234				
I hereby authorize my employer to deduct from my salary and pay to	John Doe 1234 Any Street	1254				
Standard Life and Casualty Insurance Company the premium.	Anytown, US 12345	Date				
	316					
☐ Automatic Bank Draft (Electronic Funds Transfer)	PAY TO THE ORDER OF	\$				
☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually	PAY TO THE ORDER OF EXAMPLE ANYTOWN BANK	DOLLARS				
Type of Account: ☐ Checking ☐ Savings	MEMO					
,,,	123456789 098765321	1234				
Desired withdrawal date (Between the 1st and the 28th)	_					
Bank name:	Routing Number Account Number					
City: State:	<u></u>					
Routing number (9 Digits):						
Account number:						
Authorization for Electronic  I (we) hereby authorize Standard Life and Casualty Insurance Company, here and depository, hereinafter called DEPOSITORY, to debit the same to such a COMPANY and DEPOSITORY have received written notification from me (or to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it Accountholder's Signature	einafter called COMPANY, to initiate debit entrie account. This authority is to remain in full force a reither of us) of its termination in such time and it.	nd effect until				
□ Direct Billing □ Quarterly □ Semi-Annually □ Annually						
If your billing address is different than your home address, please enter it below:						
Billing Address:						
(Street) (City	(State)	(Zip)				
(Oity	, (otato)	( <u>~</u> 'Y)				
Name of person paying, if different:						

APPLICANT B - PAYMENT OPTIONS AUTHORIZATION						
Payroll Deduction (Listbill)  Assigned list bill number, if known:  I hereby authorize my employer to deduct from my salary and pay to Standard Life and Casualty Insurance Company the premium.	John Doe 1234 Any Street Anytown, US 12345	1234 Date				
☐ Automatic Bank Draft (Electronic Funds Transfer)	PAYTO THE ORDER OF EXAMPLE	\$				
☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually	ANYTOWN BANK	DOLLARS				
Type of Account: ☐ Checking ☐ Savings	MEMO	1234				
Desired withdrawal date (Between the 1st and the 28th)	Routing Number Account Number					
Authorization for Electronic  I (we) hereby authorize Standard Life and Casualty Insurance Company, herei and depository, hereinafter called DEPOSITORY, to debit the same to such ac COMPANY and DEPOSITORY have received written notification from me (or a to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.  Accountholder's Signature	inafter called COMPANY, to initiate debit entrie ecount. This authority is to remain in full force a either of us) of its termination in such time and	ind effect until				
□ Direct Billing □ Quarterly □ Semi-Annually □ Annually						
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, LLC Notice

To obtain further information, contact Standard Life and Casualty Insurance Company 10777 Northwest Freeway, Houston, TX 77092

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 Administrative Office at the above address. 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, andyou 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 Administrative Office at the address on the front of this Notice.

#### MIB. LLC Pre-Notice

Information regarding your insurability will be treated as confidential. Standard Life and Casualty Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, LLC (MIB), a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of insurance companies that are members of MIB Group, Inc. 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 at 866-692-6901 *or go to its website www.mib.com*. 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.

Standard Life and Casualty Insurance Company, 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. Information for consumers about MIB may be obtained on its website at <a href="https://www.mib.com">www.mib.com</a>.