

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 pr	ior to comple	eting the app	lication.
Application for:	□ New Cov	erage □ Increase	e of Benefits		
If increase requested, please list UNL policy/o	certificate nui	mber(s) affected:			
SECTION I APPLICANT(S) INFORMATION SEND DOCUMENTS TO: AGENT INSURED					
Applicant 1					
Last Name	First N	ame		M.I.	
Social Security #	Social Security # □ Male □ Female Age Date of Birth			of Birth	
Weight lbs. Height	ft	in.			
Applicant 2					
Last Name First		ame		M.I.	
Social Security # 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		•	Sta		·
Applicant 1 Email Address Applicant 2 Email Address					
Applicant 1 Phone NumberApplicant 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		olicant 1 al □ Quarterly □ Monthly	□ Applicant 2 □ Annual □ Semi-Annual □ Quarterly □ Monthly		
CANCER COVERAGE (U1930-PA)	□ Option A □ Option B □ Option C □ Option A □ Option B □ Option C			tion B Option C	
Cancer Policy (U1930-PA) 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)		
Total Modal Premium					
(Includes modalized \$20 Annual	\$		\$		

SECTION III – HEALTH QUESTIONS		APPLICANT 1 APPLICANT 2		
1. For Questions 1a to 1d, in the past 10 years has any personal diagnosed as having, received medication for or been treated a. Any internal cancer, leukemia, Hogkin's or Non-Hogkin's and the second secon	by a medical professional for: gkin's disease, lymphoma,			
	malignant melanoma, sarcoma, or a pre-leukemic or pre-malignant condition? b. PSA reading greater than 4.0 or abnormal mammogram test result where cancer has not been ruled out for either condition?		□ Yes □ No	
c. Or required to use oxygen or 2 or more medications to the Chronic Obstructive Pulmonary/Lung Disease (COF		□ Yes □ No	☐ Yes ☐ No	
Chronic Bronchitis? d. Human Immunodeficiency Virus (HIV), Acquired Imm	, , ,	☐ Yes ☐ No	□ Yes □ No	
(AIDS), or AIDS Related Complex (ARC)?		☐ Yes ☐ No	☐ Yes ☐ No	
If YES for 1a through 1d, that person is not eligible for any co	overage.			
HEART ATTACK/STROKE BENEFIT RIDER (Only complete in	f applying for this rider)			
2a. In the past 5 years, has any person to be insured, had been m received medication for or been treated by a medical profes bypass, angioplasty, stent placement, coronary heart disea disease, pacemaker or defibrillator placement, heart arrhy artery disease, aortic valve disease, stroke, or Transient Is	sional for: Heart attack, heart ase angina, congestive heart ythmia, peripheral or carotid	□ Yes □ No	□ Yes □ No	
b. In the past 6 months, has any person to be insured had greater than 150 systolic or 95 diastolic?	□ Yes □ No	□ Yes □ No		
If YES for 2a or b, that person is not eligible for Heart Attack	/Stroke Benefit Rider			
ALL APPLICANTS MUST ANSWER #3				
 3. For any of the medical conditions listed above, within the person to be insured: been advised by a medical professional that a diagnosuch diagnostic test has not yet been performed or diagnostic test. 	□ Yes □ No	□ Yes □ No		
If YES, that person is not eligible for any coverage.				
SECTION IV - REPLACEMENT OF EXISTING COVERA	AGE	APPLICANT 1	APPLICANT 2	
1. Will any existing specified disease or other accident and h or changed if the proposed coverage is issued? (If "YES," Replacement Form, if required in your state.)	□ Yes □ No	☐ Yes ☐ No		
If "YES," with which company? (Applicant 1)				
If "YES," with which company? (Applicant 2)				
AGENT'S STATEMENT				
I certify that I have accurately recorded the information supplied which may have a bearing on the insurability of anyone proper it. I have advised the applicant not to withhold any information the applicant to review the application for completeness and a in writing by United National Life Insurance Company of American	osed for insurance on this ap n relative to this application a ccuracy and that no coverage	plication and any and its questions	y supplement to . I have advised	
Signature of Soliciting Agent	Signature of Secondary Ag	ent		
Print Agents Name Agent Code Print Agents Name Age			Agent Code	
Agents Email Address Agents Email Address				

APPLICANT ACKNOWLEDGEMENTS

ALL STATEMENTS MADE IN THIS APPLICATION ARE FULL, COMPLETE AND TRUE, TO THE BEST OF MY (OUR) KNOWLEDGE AND BELIEF. I (WE) UNDERSTAND THAT THE STATEMENTS FORM THE BASIS UPON WHICH INSURANCE WILL BE MADE EFFECTIVE. I (WE) UNDERSTAND THAT FRAUDULENT AND MATERIAL OMISSIONS, INTENTIONAL MISREPRESENTATIONS OR MISSTATEMENTS COULD RESULT IN DENIAL OF AN OTHERWISE VALID CLAIM AND/OR RESCISSION, VOIDING, OR REFORMATION OF INSURANCE.

I (We) understand that any changes in my (our) health conditions, from the date of this application until insurance becomes effective, may result in the declination of my (our) coverage. No agent or other representative of UNL has required, permitted, or encouraged me (us) to answer any question inaccurately or has waived any conditions of this application. I (We) have received a copy of the Pre-Notice which describes how information is obtained and used by UNL. I (We) have received an Outline of Coverage. If this application is completed electronically, I (we) 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.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I (We) authorize United National Life Insurance Company of America (herein referred to as the "Company"), insurance support organizations, authorized representatives, and any reinsurers, to obtain information as to the diagnosis, treatment, or prognosis of my (our) physical condition, other coverage and criminal or motor vehicle records needed to underwrite my (our) application for insurance. Upon presentation of this Authorization, or a photocopy of it, the Company may obtain, without restriction (except psychotherapy notes,) such information or records from any doctor, health professional, hospital, clinic, the Veterans Administration, insurance company, pharmacy benefit manager, pharmacies or pharmacy-related facility which have such information including any medical information provided to any affiliate insurance company on previous applications and medical information provided to our health division for underwriting or claim servicing purposes. The Company and its reinsurers may also obtain such information from MIB, Inc. I (We) authorize the Company, or its reinsurers, to make a brief report of my (our) personal health information to MIB, Inc. This Authorization includes all information about drugs, alcoholism, and mental illness. I (We) understand and agree that the Company or its representatives may conduct a phone interview or face-to face assessment as part of the underwriting process. Although federal regulations require that the Company inform me (us) of the potential that information disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected if such information is disclosed to a person or entity not covered by the federal privacy regulation, all such information received by the Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. I (We) agree this authorization will be valid for 24 months from the date signed. I (We) or my (our) authorized representative may have a photocopy of it. In the event my (our) application is approved and coverage is issued, I (We) acknowledge this authorization may also be used to obtain information or records, as stated above, as necessary to process a claim that is submitted within the timeframe during which this authorization remains valid.

I (We) understand that I (we) have the right to revoke this Authorization, in writing, at any time by sending written notification to my (our) agent or to the Company at the above address. I (We) understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or so long as UNL has a legal right to contest a claim under the coverage or the coverage itself. Revocation requests should be sent in writing to my (our) agent or to the attention of the Underwriting Manager. I (We) understand once information is disclosed pursuant to this Authorization, such information will continue to be protected by UNL in accordance with federal or state law. I (We) also understand that my (our) application for insurance can be declined if I (we) choose not to sign this Authorization.

This application may be completed by electronic or telephonic means. I (We) acknowledge that the Company or its agent has verified my (our) identity for this purpose in accordance with any applicable law or regulation and that if completed by electronic means, I (We) have provided my (our) consent and authorization to complete an electronic transaction to apply for coverage. This authorization shall constitute an electronic signature, which is legally binding, and has the same effect as if I (we) had physically signed this application. If this application is completed by phone, I (we) authorize the Company or its agent to accept my (our) voice signature response. I (We) agree that I (we) may receive my (our) policy and other UNL correspondence in electronic format.

I (We) acknowledge receipt of the Electronic Delivery and Communications Disclosure, which describes the requirements for Electronic Policy Fulfillment and Communications, as well as my (our) right to opt-out of Electronic Policy Fulfillment and receive a paper copy of my (our) policy (policies), free of charge.

Any person who knowingly and with intent to defraud an insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Applicant 1 Signature:	
Signed at: City and State:	Date:
Applicant 2 Signature: (if applicable)	
Signed at: City and State:	Date:
IIADDU1 10A DA	

		THORIZED PREMIUM PAYMENT PL or Withdrawals to be drawn by United		urance Company of A	America.
As a convenience and payable to the	ce to he or	My Bank's Address me, I request and authorize you to der of United National Life Insurance account to pay the same upon prese	Company of Ame		·
Account #		Ва	nk Routing#		
Account Type:		Checking Account (Attach a Voided Savings Account (Attach a Voided	• ,	applicable, or a Depo	osit 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) o	f insu	red(s) if different from premium payer	Premium payer's s	signature, as it appears	on bank records

RECEIPT	DATE
Insurance Company of America. If for any reason the a	and application for insurance to United National Life pplication is declined this payment will be refunded. No liability and of this payment, until the insurance applied for has been
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