Standard Life and Accident Insurance Company

Standard Life and Accident Insurance Company
Recovery Care Application
Mailing Address: P.O. Box 10627, Springfield, MO 65808
888.350.1488

* A P P *

RECOVERY CARE II APPLICATION

Please Print — Use Black Ink

☐ New ☐ Reinstatement-Policy Number _____ ☐ Change-Policy Number _____

SECTION A

1. Applicant _____ Date of Birth _____ Age ____ Sex ___ Height _____ Weight_____
   Home Address _____ City _____ State _____ Zip _____
   Phone _____ Email _____
2. Billing Address (if different) _____ City _____ State_____ Zip _____

SECTION B

BENEFIT AND PREMIUM DATA

3. a) Daily Benefit $_____ b) Lifetime Maximum Benefit Period (days): ☐ 180 ☐ 270 ☐ 360
   c) Elimination Period (days): ☐ 0 ☐ 20 d) Inflation Protection Rider: ☐ Compound ☐ Simple
   e) ☐ Home Health Care Rider (if Inflation Protection Rider included in Base Plan, it must be included in Home Health Care Rider)
4. **Billing Mode**: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly PAC ☐ Monthly Credit Card ☐ List Bill
5. **Requested Effective Date:** _____

SECTION C

If the answer to any question in Section C (6-9f) is Yes, the application should not be submitted.

6. Are you now bedridden, confined to a nursing home, assisted living facility or hospital, or receiving the services of a home health care agency? ..... ☐ **Yes** ☐ **No**
7. Within the past **10 years**, have you ever had a positive result on a test for, or been diagnosed as having acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection? ..... ☐ **Yes** ☐ **No**
8. Within the past **2 years**, have you:
   a) had or been recommended to have medical tests or treatment or surgery which have not been done or for which results have not been given (this question does not apply to AIDS, ARC or HIV)? ..... ☐ **Yes** ☐ **No**
   b) been hospitalized 2 or more times or confined to a nursing home or required assistance or supervision by another person for dressing, eating, personal hygiene (bathing or toileting), walking or transferring to or from a bed or chair or suffered a fracture of the spine or hip? ..... ☐ **Yes** ☐ **No**
   c) required the use of a wheelchair, walker or cane? ..... ☐ **Yes** ☐ **No**
9. Do you now have or within the past **2 years** have you had or been advised to have treatment, surgery or to take prescription medication for:
   a) internal cancer (excluding basal or squamous cell), Hodgkin's disease, lymphoma, leukemia, or malignant melanoma; even if the conditions are in remission? ..... ☐ **Yes** ☐ **No**
   b) peripheral vascular disease, circulatory disorder, congestive heart failure, transient ischemic attack, stroke, heart attack, heart or heart valve surgery? ..... ☐ **Yes** ☐ **No**
   c) insulin dependent diabetes, amputation due to disease, liver disease, disease of the pancreas, Addison's disease, kidney failure, renal insufficiency or kidney dialysis? ..... ☐ **Yes** ☐ **No**
   d) emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), chronic obstructive lung disease (COLD), or any chronic pulmonary disease requiring the use of oxygen? ..... ☐ **Yes** ☐ **No**

SECTION C - *continued*

e) Paget's disease, organ transplant other than corneal, any ostomy present due to disease, osteoporosis with history fractures, rheumatoid or disabling arthritis, lupus or other bone or connective tissue disorder? ☐ Yes ☐ No

f) psychotic disorder, memory loss, organic brain disorder, Alzheimer's disease, ALS (Lou Gehrig's disease), nervous system disorder, motor neuron disease, Huntington's Chorea, muscular dystrophy, myasthenia gravis, Parkinson's disease, multiple sclerosis, cerebral palsy, neuropathy, paralysis, senile dementia or other senility disorders or alcohol, drug or substance abuse? ☐ Yes ☐ No

10. Are you currently taking any prescription medications? If Yes, provide details below. ☐ Yes ☐ No

Name and dosage of medication

Reason taken

Primary or Family Physician _____ Phone _____

Address _____

Date of last visit _____ Reason _____

SECTION D

Will any health, recovery short term, long term, or home health care insurance be replaced with this policy? ☐ Yes ☐ No

If Yes, which company? _____ Policy Number _____

If Yes, read and complete the Notice to Applicant Regarding Replacement.

SECTION E

DECLARATION AND AGREEMENT — I have read or had read to me my completed application. My answers are true and complete to the best of my knowledge and belief. I understand that this information will be used to determine my eligibility for coverage under the Policy and any false statement or misrepresentation may result in loss of coverage or claim denial. The Applicant must be eligible based on the Company's rules in effect on the date of Application and on the Policy Effective Date. Policy coverage (or Reinstatement of coverage), if issued and approved by the Company, will become effective on the date recorded in the Policy Schedule of Benefits and not the date this Application is signed. I understand that no agent or producer can accept risks, modify policies, or waive any rights or requirements of the Company. If this Application is completed electronically, I agree that my electronic signature serves as my original signature.

ACKNOWLEDGMENT— If Medicare eligible, I have received the *Guide to Health Insurance for People with Medicare* and a Duplication of Medicare Coverage form from the Agent.

FRAUD WARNING — 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.

The policy provides limited benefits. Review your policy carefully.

Applicant's Signature _____ Date _____

City _____ State _____ Zip _____

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AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any: physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, pharmacy benefit manager, government agency, group policyholder, employer, benefit plan administrator, MIB,Inc., the Department of Motor Vehicle Registration and paramedical facility to provide to STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on STANDARD LIFE AND ACCIDENT INSURANCE COMPANY's or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other Applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Applicant(s). It is understood that STANDARD LIFE AND ACCIDENT INSURANCE COMPANY underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it, resulting in loss of protection by federal regulations.

I understand that: **1.** such information will be used by STANDARD LIFE AND ACCIDENT INSURANCE COMPANY for underwriting and insurability determinations; **2.** I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain health insurance coverage; **3.** a picture copy or photocopy of this authorization shall be as valid as the original; and **4.** I, or my authorized representative, am entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, P.O. Box 1991, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under this authorization, if signed.* If application taken over the phone, I agree that my electronic signature serves as my original signature.

Date _____ Applicant's Signature _____

Witness _____ Personal Representative designated by signature above is hereby authorized to execute this instrument based on: (circle one) power of attorney, guardian, guardian-in-fact, payee representative or other _____

AUTHORIZATION FOR BILLING

I am signing up for an automatic payment plan. I agree Standard Life and Accident Insurance Company or its authorized agent may automatically debit my bank account or Credit Card for the amount due on or around the payment due date. I can cancel the automatic payment at any time by calling or writing Standard Life and Accident Insurance Company or its authorized agent at least 30 days prior to the next due date. I agree that Standard Life and Accident Insurance Company, its authorized agent, or my financial institution can cancel automatic payment for my account for any reason, at any time, with or without prior notice to me. I understand that $25.00 will be charged for each transaction rejected for insufficient funds. I acknowledge that the origination of these debits to my account must comply with U.S. laws. I agree that this agreement remains in effect until cancelled by Standard Life and Accident Insurance Company, its authorized agent, my financial institution, or me. I have a copy of this agreement and I know I can also contact the insurance company or its agent for a copy. I further agree that should any electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. Where applicable, I agree that my electronic or recorded signature serves as my original.

Account Holder's Name _____ Account Holder's Signature (as it appears on bank records) _____ Date Signed _____

Insured's Name (if different than Account Holder) _____ Insured's Signature (if different than Account Holder) _____ Date Signed _____

PLEASE SELECT ONE:

☐ **Checking**

☐ **Savings**

☐ **Credit Card**

Bank Name _____

City _____ State _____ Zip _____

Bank Account Number _____ Bank Routing Number _____

Credit Card _____ (Last 4 digits) Expiration Date: _____ Profile ID _____

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AGENT'S STATEMENT

As Agent, I have complied with all legal and company requirements and if applicable, the Applicant has read and signed the Notice to Applicant Regarding Replacement.

I hereby certify that all information set forth in the application is complete and correct to the best of my knowledge and was accurately recorded.

The Company names, policy/certificate numbers and types of coverages of any other health insurance policies that I sold to the Applicant and which are currently in force are (if none, write "NONE"): _____

The Company names, policy/certificate numbers and types of coverages of any other health insurance policies that I sold to the Applicant during the past 5 years and which are not currently in force are (if none, write "NONE"): _____

If applicable, the Guide to Health Insurance for People with Medicare and a copy of the appropriate form(s) and/or disclosure(s) have been provided to the Applicant.

AGENT INFORMATION

Name (printed) _____ Signature _____

Agent Code _____ Date Signed _____

Email _____ Fax _____ Phone _____

☐ Preferred Underwriting ☐ Spousal Discount

Premium Quoted $ _____

☐ **Premium collected with Application.**

☐ **Initial premium is to be:** ☐ **Drafted** ☐ **Charged** **Profile ID** _____

Requested Subsequent Draft Date _____

☐ **Credit card initial payment only. Recurring premium bank draft.**

Mail Policy to: ☐ Insured ☐ Agent

A TELEPHONE INTERVIEW WILL BE CONDUCTED.

What will be the best time to contact the Applicant for the telephone interview?_____ ☐ a.m. ☐ p.m.

☐ **Telephone interview was completed at point of sale**

Special Requests:

RECEIPT

IF PREMIUM IS COLLECTED, CHECK OR MONEY ORDER FOR INITIAL PREMIUM MUST ACCOMPANY APPLICATION. ALL CHECKS AND MONEY ORDERS MUST BE PAYABLE TO STANDARD LIFE AND ACCIDENT INSURANCE COMPANY. If coverage is not issued, the initial premium will be refunded to the Applicant. If coverage is issued, it will begin on the date of issue shown in the policy.

Received from _____ on _____
Date

an application for RecoveryCare II and a Check ☐ Money Order ☐ for $ _____

Applicant's Signature _____

Agent's Signature _____

DISCLOSURE NOTICE

Fair Credit Reporting Act Pre-notification – Federal and state laws require notification that, with your application, we may request an investigative consumer report. In addition, such a report may be requested subsequently to update our records or if you apply for additional coverage. Upon written request, we will inform you whether or not an investigative consumer report was requested and, if such report was requested, the address and telephone number of the investigative agency to which the request was made. By contacting the local office and providing the proper identification, you may inspect, or for the appropriate fee, receive a copy of such report. Typically, the report will contain information as to character, general reputation, personal characteristics, and mode of living, which information is obtained through an interview with you or an adult member of your family, employers or business associates, financial sources, friends, neighbors, or others with whom you are acquainted. The information will consist, when applicable, of a confirmation of your identity, age, residence, marital status, and past and present employment including occupational duties, financial information, driving record, sports and recreational activities, health history, use of alcohol or drugs if any, living conditions and type of community.

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