*NBAP*WNIC*CN*

Application to: Washington National Insurance Company Home Office: 11825 N. Pennsylvania St., Carmel, Indiana 46032-4555

SECTION I Cancer Coverage Enrollment Form/Application

Is this a reinstatement? Yes ☐ No ☐ Is this an upgrade of existing coverage? Yes ☐ No ☐
Is this a conversion of existing coverage? Yes ☐ No ☐ Is this a guaranteed conversion? Yes ☐ No ☐
If "Yes" to any of the above, provide existing policy number:_____
Requested Effective Date:_____

SECTION II Enrollee/Applicant Information

Please Print Primary Enrollee/Applicant's Name (First, Middle Initial, Last)

(Enrollee/Applicant) ☐ Male ☐ Female	Date of Birth (mm/dd/yy)	Age	Social Security Number	(Area Code) Phone Number

Spouse's Name (If applying for Spouse Insurance) (First, Middle Initial, Last)	(Spouse) ☐ Male ☐ Female

Date of Birth (mm/dd/yy)	Age	Social Security Number	If applying for Child(ren) Insurance, complete Section V.

Enrollee/Applicant's Street Address

City State Zip Code

E-mail Address:

Employer's Name & Department:

SECTION III Health Questions

Please answer the questions below for the type of insurance being applied for, and answer all applicable questions. If you answer "yes" to any of the health questions, the person(s) named in the section(s) will be partially or completely excluded from coverage by an Exclusion Rider to be signed by the person applying for coverage before we issue the coverage.
Do not complete this section if you are applying through a guaranteed conversion.

For Cancer Coverage:

1. Has anyone to be covered ever been treated for or diagnosed as having cancer in any form? ☐ Yes ☐ No
   If "yes," indicate the type of cancer, name(s) of person(s) and complete the appropriate section of the Exclusion Rider.
   ☐ non-melanoma skin cancer. Name(s) of person(s):_____
   ☐ any melanoma cancer. Name(s) of person(s):_____
   ☐ non-melanoma internal cancer. If cancer-free for more than 10 years, a Cancer Treatment History form will be required. Name(s) of person(s):_____

2. Has anyone to be covered been treated for or diagnosed as having a pre-leukemic condition, a pre-malignant condition or a condition with malignant potential within the last 10 years? ☐ Yes ☐ No
   If "yes," indicate name(s) of person(s) and complete the appropriate section of the Exclusion Rider:_____

3. In the past 10 years, have you been treated for or diagnosed by a physician as having Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? If "yes," indicate name(s) of person(s) and complete the appropriate section of the Exclusion Rider:_____	☐ Yes ☐ No
For Intensive Care Rider: 4. Has anyone to be covered ever been treated for or diagnosed as having a heart attack, heart trouble or any abnormality of the heart? If "yes," indicate name(s) of person(s) and complete the appropriate section of the Exclusion Rider:_____	☐ Yes ☐ No

SECTION IV Coverage Selection

Cancer: ☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D

Additional First Occurrence Benefit: # of units:_____ (Maximum: 9 additional units)

Optional Riders:

☐ Return of Premium/Cash Value (not available with Section 125) ☐ Alternative Care Rider

☐ Cancer Death Benefit Rider ☐ Cancer Preventive Care Rider

☐ Intensive Care Rider ☐ $500 ☐ $750 ☐ $1,000

Select Type of Coverage:

☐ Individual ☐ Single Parent ☐ Family

SECTION V Dependent Child Coverage (Please Print and fill out completely)
(Each Child to be insured must meet policy eligibility requirements)

Name	Child(ren) Relationship to Primary Enrollee/Applicant	Date of Birth

☐ Check here if additional space is needed and attach separate sheet.

SECTION VI	Payment Information
Payment Mode:	Premium Total:

Current Direct Bill Options:

☐ Monthly Bank Draft

☐ Semi-Annual

☐ Annual

Current Payroll Bill Options:

☐ Payroll deduction
☐ Federal Allotment
Frequency:
☐ 9 ☐ 10 ☐ 12 ☐ 13 ☐ 24 ☐ 26 ☐ 52

☐ Section 125

Monthly Bank Draft is the only mode available on the following:
☐ Credit Union

Account Number_____

☐ Employee Non-payroll

Account Number_____

Cancer $_____

Additional 1st Occurrence Express Benefit $_____

Intensive Care Rider $_____

Alternative Care Rider $_____

Cancer Death Benefit Rider $_____

Cancer Preventive Care Rider $_____

Other $_____

Total $_____

Amount Collected $_____

☐ Draft initial premium payment (an "Authorization to Draft Initial Premium" form must be completed.)

☐ Check remitted with enrollment form/application

*All checks should be payable to: Washington National Insurance Company

Special Instructions:

SECTION VII Enrollee/Applicant's Statement and Authorization to Obtain Information

I have read or have had read to me, the completed enrollment form/application; all representations are true and complete. I understand that: any false statements or misrepresentations in this enrollment form/application may result in loss of insurance if such false statement materially affected either the acceptance of the risk or the hazard assumed by the Company. The agent has no authority to approve the enrollment form/application, change the certificate/policy or waive any certificate/policy provisions. No coverage will be effective until all eligibility requirements are met and until the later of: (1) the Effective Date as shown on the Certificate/Policy Schedule, if issued; or (2) the date the first premium is accepted by Washington National Insurance Company.

If age 65 or over, I acknowledge receipt of the booklet containing insurance advice for people eligible for Medicare.

In addition, I authorize the Company to obtain information about other insurance products applied for or purchased from the Company and its affiliated insurance companies by me, my spouse or my dependents as listed on this enrollment form/application. This authorization shall be valid for twenty-four (24) months. A copy of this Authorization is as valid as the original.

WARNING: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an enrollment form/application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Date:_____ Signature of Enrollee/Applicant:_____

Printed Name:_____

Where Signed:_____
(City, State)

SECTION VIII Agent's Statement

This Section to be Completed by Agent: I hereby certify that I have explained to the enrollee/applicant all exceptions and limitations pertaining to the coverage applied for, including any concerning pre-existing conditions. I hereby certify that I have truthfully and accurately recorded in this enrollment form/application the information supplied by the enrollee/applicant. I further certify that I am a licensed agent in the state where this enrollment form/application is being solicited by me and signed by the enrollee/applicant.

Date:_____ Signature of Agent:_____

Agency:_____ Agent Number:_____

Agent's E-mail address:_____

Agent's Phone Number:_____

☐ Mail to Certificateholder/Policyholder ☐ Mail to Agent