Application book | Nebraska

ACCIDENT*assure*®

ACCIDENTAL INJURY & DISABILITY INCOME INSURANCE

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

SECTION I	**Accident Insurance Application**

Is this a reinstatement? Yes ☐ No ☐ Is this an upgrade 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				**Applicant Information**	
Please Print Primary Applicant's Name (First, Middle Initial, Last)					
(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 VI.		
Applicant's Street Address					
City				State	Zip Code
E-mail Address:					
Beneficiary's Full Name				Relationship to Primary Applicant:	

SECTION III	**Employer Information**	
Employer's Name:		
Occupation: ________________ Hours per week worked at this job ________	Length of time employed by this employer: ________Years ________Months	Job Class (circle one) 1 2 3 4

SECTION IV **Health Questions**

Do not complete this section if you are applying through a guaranteed conversion.

Please answer the questions below for the type of insurance being applied for:

For All Insurance Applied For:

1. Will this insurance replace any accident and sickness insurance currently in force with us or another company for any person to be insured? ☐ Yes ☐ No
   If "Yes," please complete the "Notice to Applicant" form.

2. Do you own any other accident, hospital indemnity and/or disability insurance which is not being ended (not including Worker's Compensation)? ☐ Yes ☐ No
   If "Yes", complete the appropriate information below.

Other Accident and Sickness Insurance (Please Print and fill out completely.)

Name of Company	Type of Insurance	Monthly Benefit Amount(s)

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

3. Within the past 5 years, have you or any person applying for coverage been convicted of a felony, reckless driving, or driving under the influence of drugs or alcohol? ☐ Yes ☐ No
   If "Yes", the named individual(s) is not eligible for coverage. Please list individual(s) name:_________
   ____

For Disability Coverage (Only available for Primary Applicant).

4. Provide your gross monthly income from your employer as listed in Section III, Employer Information. Gross monthly income for the purposes of this application is your regular income excluding overtime, bonuses, and any incentives. $____________

If the answer to any question 5 through 8 is "Yes", you are not eligible for the disability coverage.

5. Are you covered under any other disability income insurance which is not ending and when combined with this application for insurance will exceed 66 2/3% of your monthly gross income (pre-tax)? Please include only disability income coverage with an elimination period/waiting period of 30 days or less. ☐ Yes ☐ No

6. Are there any material or substantial job duties you are currently unable to perform due to sickness, maternity or injury? ☐ Yes ☐ No

7. In the past 12 months have you been off work for 10 or more consecutive workdays due to illness or injury (other than for normal pregnancy)? ☐ Yes ☐ No

8. In the past 6 months, have you taken prescribed medication for the treatment of an injury, disease or disorder of the back, neck or joints? ☐ Yes ☐ No

For Sickness Disability Rider (Only available for Primary Applicant). If the answer to any question 10 through 13 is "Yes", you are not eligible for the Sickness Disability Rider.

9. What is your height and weight?

Height _________

Weight _________

10. In the past 10 years, have you been treated for or diagnosed by a physician as having any of the following conditions? ☐ Yes ☐ No

Alzheimer's Disease	Cardiomyopathy
Chronic Fatigue Syndrome	Chronic Hepatitis
Chronic Liver Disease	Chronic Obstructive Pulmonary Disease (COPD)
Crohns Disease	Emphysema
Fibromyalgia	Heart Valve Replacement
Insulin Dependent Diabetes	Diabetes Diagnosed Prior to age 40
Multiple Sclerosis	Muscular Dystrophy
Pulmonary Fibrosis	Regional Enteritis/Ileitis
Rheumatoid Arthritis	Psoriatic Arthritis
Rheumatic Fever	Stroke or TIA (mini-stroke)
Systemic Lupus	Cerebrovascular Accident
Ulcerative Colitis	Schizophrenia
Vascular Insufficiency	Parkinson's Disease

11. 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)? ☐ Yes ☐ No

12. In the past 5 years, have you been treated for or diagnosed by a physician or had surgery for any of the following conditions: ☐ Yes ☐ No

Angina and/or Chest Pain	Atrial Fibrillation
Carpel Tunnel Syndrome	Congestive Heart Failure
Coronary Artery Disease (CAD)	Coronary Angioplasty
Heart Disease or Disorder	Coronary Bypass Surgery
Drug or Alcohol Abuse	Heart Attack
Kidney Disease	Sciatica
Cancer	

13. In the past 12 months, have you been confined to a hospital or received medical treatment in an emergency room for any of the following: ☐ Yes ☐ No

Sickle Cell Anemia	Hypertension
Chronic Bronchitis	Asthma
Epilepsy/Seizure	Pancreatitis
Gastric Bypass	Blood Disorder
Diverticulitis	Joint Replacement
Mental or Nervous Disorder	Aneurysm

SECTION V — Coverage Selection

Accidental Death and Dismemberment (base coverage only) ☐ Level 1 ☐ Level 2

Disability Coverage/Rider Options (*Available to Primary Applicant only)

☐ Off the Job Disability* ☐ 24 hour Accident Short Term Disability* ☐ Sickness Disability Rider*
☐ Waiver of Premium Rider* ☐ None

Choose One Disability Benefit Amount, this amount will be for any disability coverage or disability rider selected (based on income):

Disability Coverage:
☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,000

Sickness Disability Rider:
☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,000

Optional Riders:

☐ Public Safety* ☐ Return of Premium/Cash Value** ☐ Physician's Office Additional Benefits Rider

*only available for Primary applicant **not available with Section 125

Select Type of Coverage:

☐ Individual ☐ Individual plus child(ren) ☐ Individual plus spouse ☐ Family

SECTION VI — 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 Applicant	Date of Birth

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

SECTION VII	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____________________	Base Coverage $____________ Sickness Disability Rider $____________ Public Safety Rider $____________ Physician's Office Additional Benefits Rider $____________ Total $____________ Amount Collected $____________ ☐ Draft initial premium payment (an "Authorization to Draft Initial Premium" form must be completed.) ☐ Check remitted with application *All checks should be payable to: **Washington National Insurance Company**
Special Instructions:	

Applicant
signature here ➤

SECTION VIII **Applicant's Statement and Authorization to Obtain Information**

I have read or have had read to me, the completed application; all representations are true and complete. I understand that: any false statements or misrepresentations in this 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 application, change the policy or waive any 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 Policy Schedule, if issued; or (2) the date the first premium is accepted by Washington National Insurance Company.**

I acknowledge receipt of an Outline of Coverage; if age 65 or over the booklet containing insurance advice for people eligible for Medicare; and the Disclosure Statement, which includes the Medical Information Bureau Notice, the Notice of Insurance Information Practices and the Fair Credit Reporting Act Notice.

1. **This authorization to obtain and disclose information complies with HIPAA regulations as they relate to accident insurance.** I authorize Washington National Insurance Company or its representatives (Company) to obtain and use any information about or relating to me that may affect my insurability. The Company may obtain and use health and medical information, including but not limited to information about drug use, alcohol use, nicotine use, physical and mental diseases and illness, and psychiatric disorders. The Company may also obtain and use non-health and non-medical information including but not limited to financial information, credit reports, consumer reports, driving record, criminal record, and information about avocations and aviation activity. All this information may be used to evaluate an application for insurance, a claim for insurance benefits or both.

2. I authorize the following persons and organizations to release and disclose the information described in paragraph 1 to the Company or its representatives acting on its behalf: i) my doctor(s); (ii) medical practitioners; (iii) pharmacies and pharmacy-related organizations; (iv) medical and related facilities, including hospitals, clinics, facilities run by the Veteran's Administration; (v) insurers; (vi) reinsurers; (vii) Medical Information Bureau (MIB); (viii) my current and previous employers; and (ix) commercial consumer reporting agencies (CRA). All of these persons and organizations other than MIB may release information described above to a CRA acting for the Company. MIB may not release the information described in paragraph 2 to a CRA.

3. I authorize the Company to release and disclose the information described in paragraph 1 to its affiliates, reinsurers, persons or organizations providing services relating to insurance underwriting for the Company, MIB, and as otherwise required or permitted by law. The Company may release and disclose the information described in paragraph 1 to the insurance Agent to provide an explanation of the reason(s) for the Company's underwriting decisions about me, or in connection with my claim(s) for benefits.

4. I understand that: (i) I have the right to revoke this Authorization by writing to the Company – Attention New Business, 11825 N. Pennsylvania Street, Carmel IN 46032; (ii) if I revoke this authorization, the Company will not be able to evaluate this application for accident insurance or subsequent claim(s) if a policy is issued to me; (iii) signing this authorization does not effect my ability to obtain health care benefits (treatment/payment/enrollment); and (iv) authorizing the release or disclosure of health information to persons not regulated by HIPAA may result in the information being redisclosed.

5. This authorization shall be valid for twenty-four (24) months or, in the event of a claim for benefits, for the duration of the claim. A copy of this Authorization is as valid as the original.

6. I am entitled to a copy of this Authorization upon request.

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

Date:________________________ Signature of Applicant:____

Printed Name:____

Where Signed:____
(City, State)

Agent
signature here ➤

SECTION IX	Agent's Statement

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

Worksite Business Only: ☐ Submitted for Guaranteed Issue
NOTE: Guaranteed Issue Rules apply. If the group does not meet participation requirements, the application will not qualify for Guaranteed Issue.

Date:________________________Signature of Agent:____

Agency:____Agent Number:__________________

Agent's E-mail address:____

Agent's Phone Number:____

☐ Mail to Policyholder ☐ Mail to Agent

PRIVACY NOTICE

HOW HEALTH AND FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND SHARED
YOUR RIGHT TO ACCESS THIS INFORMATION—PLEASE REVIEW CAREFULLY

Our Privacy Commitment

This notice applies to you as a prospective, current or former customer. It describes what we do with your **Personally Identifiable Information ("PII")**. It also describes the choices you have about PII in our care.

PII is information that clearly identifies you. Examples of PII are your name, address, Social Security number, information about your health and finances, and other nonpublic information.

We will not ask for your PII unless it is reasonably necessary to issue or service your insurance with us.

This notice covers the insurance companies owned or controlled by CNO Financial Group, Inc. ("Affiliates" or "Affiliated Companies"), which are listed below.* We may change our privacy practices at any time. For purposes of federal health privacy law, we are an affiliated covered entity. This means that our health insurance plans comply with federal health privacy laws as a single entity.

Protecting Your Information

Your trust is important to us. We take your privacy seriously. We limit access to our buildings and our information systems to authorized persons. We have policies and procedures designed to keep PII safe and secure. We train our personnel to make privacy a priority. We use privacy and security safeguards that obey state and federal regulations. If state law is stricter than federal law, then we will follow the stricter law.

Types of PII We Collect and Why We Collect It

Mostly, we collect your PII directly from you. You provide PII when you apply for insurance, make a claim for benefits or ask us to perform a transaction on your policy. We need your name and contact information, date of birth and may need your Social Security number. Depending on the coverage you apply for, we may ask you about your past or present health status and financial assets.

We also collect your PII from third parties. We may need medical records or consumer credit reports to underwrite your coverage or to process insurance claims. However, we are prohibited from using or disclosing your health information that is genetic information for underwriting purposes, excluding for the issuance of long term care policies. We may get reports from MIB, Inc., a nonprofit insurance support organization that exchanges information with its members. We may ask about the insurance you have with an Affiliated Company, such as the amount of your coverage or your payment history. We get your authorization to obtain this information, unless the law allows otherwise.

We use your PII for the purpose of issuing and servicing your insurance coverage. The issuing company may also use your PII to offer you other products and services. **However, we do not use your health information for marketing purposes unless the law allows it.**

Sharing PII Fairly and Legally

We may share your PII with nonaffiliated companies that perform services for us in order to help administer your policy, or with whom we have joint marketing agreements. These companies are also required to maintain strict privacy and security standards. You cannot restrict this type of sharing.

We may share your PII with Affiliated Companies or nonaffiliated companies as allowed by law such as to protect the security of our records, to meet legal or regulatory requests, or to follow state, federal or local laws. We may share a limited amount of PII provided by you with MIB, Inc. You cannot restrict this type of sharing.

Your Opt-Out Rights

If you do not want us to share your PII (except as permitted by law) with Affiliated Companies or nonaffiliated companies you may call the toll-free number listed below. If you previously opted out of Affiliate sharing, your election is effective for five years. If you previously opted out of nonaffiliated company sharing, your election is effective until you revoke it.

California, Montana, New Mexico, North Dakota and Vermont Residents

We will not share your PII with nonaffiliated companies for marketing purposes. You do not need to take any action to opt out of this kind of sharing. However, we still may share your PII with nonaffiliated companies for purposes that are allowed by law.

***Bankers Life and Casualty Company, Bankers Conseco Life Insurance Company [a New York licensed and domiciled insurance company], Colonial Penn Life Insurance Company, Conseco Life Insurance Company, Conseco Life Insurance Company of Texas, Washington National Insurance Company.**

Vermont Residents

For marketing purposes, we will only disclose your name, contact information and information about your transactions with us to nonaffiliated third parties with whom we have joint marketing agreements.

To Opt Out – Call us at 800-783-7720

Our automated opt out line will lead you through your choices. Please have your policy number ready.

Or Write to us at P.O. Box 2031, Carmel, IN 46082-2031

You may opt out of Affiliate sharing or nonaffiliated company sharing by writing to us. Please, provide your full name, current mailing address and policy number(s).

Your Right to Access Your PII

You have the right to access the PII we maintain about you. If you wish to do so, write to us at the address listed at the bottom of this notice. Please provide your full name, address, and policy number(s). We will respond within the time frame required by law, generally about 30 days after receipt. We will provide this information free of charge once a year; otherwise, we may make a reasonable charge for copying and postage.

Your Right to Correct Your PII

You have the right to correct your PII. Even if we have contradictory information, we will keep your request with your file for as long as you are our customer. If we agree to your request, we will make reasonable efforts to communicate the correction or amendment to other parties who may need this information. We do not have to accommodate your request if we did not create the PII, if we do not maintain the information, or if your PII is already accurate and complete. To give your request careful consideration, provide us with a written request signed by you or your legal representative. If we deny your request, we will explain our reasons in writing and let you know how to file a complaint with us and regulatory agencies.

Your Right to Request an Accounting of Disclosures of Your PII

You may request a record of disclosures of your PII made within the last six years. We are not required to provide an accounting of disclosures made for payment activities, health care operations or based on a valid written authorization. Your request must state a specific period of time that may not be longer than six years and may not include dates before April 14, 2004. Provide us with a written request signed by you or your legal representative. We will provide this information free of charge once a year; otherwise, we may make a reasonable charge for each additional accounting request.

Your Right Regarding Adverse Underwriting Decisions

If your insurance coverage is denied, terminated, offered at a rate higher than standard rates, or if your insurance representative did not apply for the insurance coverage that you requested, you will receive a written explanation of the specific reason for the decision as well as a summary of your right to access and correct your PII, or you will be advised that you may receive this information by writing to us at the address listed at the bottom of this notice. You must submit your request within 90 business days of the underwriting decision. We will provide a response within 21 business days.

Your Right to File a Complaint

If you have a privacy related complaint, please let us know so we can address your concern. Write to us at P.O. Box 2031, Carmel, IN 46082-2031. You may also file a complaint with your state department of insurance. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C. within 180 days of the conduct. Neither filing a complaint with a regulatory agency or us will adversely affect your status as our customer or the services you receive from us.

Additional Privacy Rights for Health Insurance

Your Right to Request Alternative Means of Communication

You have the right to request that we communicate with you by alternative means, such as directing your mail to a post office box. We will try to accommodate your request if it is reasonably possible for us to do so. We are required to accommodate reasonable requests if you inform us that disclosure of all or part of your PII could place you in danger. Provide us with a written request signed by you or your legal representative.

Your Right to Request a Restriction on Communications

You may request that we restrict our disclosures of your PII (including health information) to or from certain persons. We are not required to comply with your request. If we cannot comply with your request, we will explain that to you in writing. Provide us with a written request signed by you or your legal representative. We reserve the right to terminate your request if we believe it is appropriate. If this happens, we will notify you in writing. You can terminate a restriction request by letting us know in writing or by phone.

Your Right to Breach Notification

You have a right to be notified following a breach of your unsecured PII.

Additional Privacy Standards for Health Insurance

We are subject to additional privacy standards for health insurance. Most uses and disclosures of psychotherapy notes, uses and disclosures of health information for marketing purposes and disclosures that constitute a sale of health information require your authorization. Except as listed below, we will not disclose your PII without a valid written authorization, which you may revoke at any time. Remember, PII includes specific health information about you, including information regarding payment for health care.

- **Payment and Health Care Operations** - The law permits us to disclose your PII to an organization subject to federal health privacy laws when conducting payment activities or health care operations. For instance, we may share your PII with your health care providers in connection with settling your claims. Also, we may use your PII as required to conduct internal quality audits or in connection with reinsurance, mergers or acquisitions.
- **Caregivers or Emergencies** - The law permits us to disclose a minimum amount of your PII to persons involved in your care, or in an emergency.
- **Public Interest** - The law permits us to disclose your PII if it is required by law, for fraud prevention or law enforcement. We may disclose your PII to a state or federal agency, including the U.S. Department of Health and Human Services for compliance purposes. We may disclose your PII to comply with a court order or if we believe you are a victim of abuse, neglect or domestic violence.

Fair Credit Reporting Act Notice

As part of our underwriting procedures, we may get an investigative consumer report. The report will contain information about your character, general reputation, personal characteristics and mode of living. The information is obtained through interviews with your friends, neighbors and associates. You have a right to ask for details on the nature and scope of this report. You have the right to contact the consumer reporting agency to review a copy of the report. If you write to us we will let you know if we have in fact obtained a report; and, if so, the name and the address of the agency making the report.

MIB Notice

Information regarding your insurability is confidential. We (or our reinsurers) may make a brief report to MIB, Inc. MIB is a non-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance, or submit a claim for benefits, MIB, upon request, will supply that company with information it may have in its file. We (or our reinsurers) may release information in our files to other insurance companies to whom you might apply for life or health insurance, or submit a claim for benefits.

If you request it, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of any information in the Bureau's files, you may contact MIB and seek correction in accordance with the procedures of the Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. MIB's telephone number is (866) 692-6901. Information for consumers about MIB is available on its website at www.mib.com.

Contact Us

For more information about this notice, call us at 800-783-7720 or write to us at P.O. Box 2031, Carmel, IN 46082-2031.

This notice is effective as of September 23, 2013.

Important Privacy Choices for Consumers

If you do not want us to share your PII for marketing purposes, you can opt out.

☏ Call us toll-free at 800-783-7720. Please have your policy number ready.
🖷 Fax this form to 800-757-6324.
🖃 Mail this form to P.O. Box 2031, Carmel, IN 46082-2031. (CA residents may be provided a pre-addressed envelope.)

My Opt Out Choices

☐ Do not share my PII with nonaffiliated companies for marketing purposes. This opt out choice is effective until I revoke it.
☐ Do not share my PII with Affiliated Companies* for marketing purposes. This opt out choice is effective for 5 years.

My Information

Printed Name ______________ Policy Number(s) ______________ Date ______________

Address ______________ City ______________ State ______________ Zip Code ______________

*Bankers Life and Casualty Company, Bankers Conseco Life Insurance Company [a New York licensed and domiciled insurance company], Colonial Penn Life Insurance Company, Conseco Life Insurance Company, Conseco Life Insurance Company of Texas, Washington National Insurance Company.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to Your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Washington National Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present coverage.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all of the relevant factors involved in replacing your present policy.

3. If, after due consideration, you still wish to terminate your present policy and replace it with the new policy, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

____
Date

____
Applicant's Signature

____
Date

____
Spouse's Signature (if applying)

Applicant Copy

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to Your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Washington National Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present coverage.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all of the relevant factors involved in replacing your present policy.

3. If, after due consideration, you still wish to terminate your present policy and replace it with the new policy, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

____
Date

____
Applicant's Signature

____
Date

____
Spouse's Signature (if applying)

Home Office Copy

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductible or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services.

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

BEFORE YOU BUY THIS INSURANCE

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

____
Signature of Applicant

For use with Accidental Injury policies.

Washington National Insurance Company
11825 N. Pennsylvania Street
Carmel, IN 46032

Request to draft premium by Electronic Funds Transfer (EFT)

Please check the appropriate options.
Be sure to include a VOIDED CHECK or this request cannot be processed!

1. Home office will process the draft for the initial premium within 48 hours of receiving the application.
2. Include a copy of a voided check with the initial premium by EFT in the special remarks section of the application.
3. Complete the authorization form below.
4. **Fax completed form with application to:**
   - **For individual sales: (800) 906-3926, Attn: New Business department.**
   - **For worksite sales: (800) 981-8413**

☐ **Authorization to draft initial premium**
Upon the receipt of this form, please process a draft for the initial premium, in the amount of $____________, for the application shown below. I am aware that the draft may be processed within 48 hours of receipt of this request in the home office.

☐ **Yes! Please deduct future premiums.**
By selecting this option, you are authorizing subsequent renewal premiums to be deducted from the bank account listed below. These premiums will be deducted on a monthly basis on the ____________day of the month.

Application name____

Date of birth or SSN______________________________________

Accountholder name (if different)______________________________

Financial institution/Bank name ______________________________

ABA routing no.____________________ ACH routing no. ____________________

Bank account no. ____________________ Checking ☐ Savings ☐

Accountholder signature ____________________________ Date __________________

I hereby request and authorize the charge to my account deductions drawn on my account by and payable to Washington National Insurance Company. The signatures on such deductions may be either typed or printed. If any such deductions are dishonored, either 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. This authorization shall continue in force until revoked by me in writing and received by the company, a copy of which revocation shall be sent by me to the company, at its home office in Carmel, Indiana. The plan may be discontinued by the company upon thirty (30) days written notice to the owner indicated in the agreement. The company is instructed to forward authorization to you.

The acceptance of this form and the initial premium payment is not a guarantee that the application for insurance will be approved and a policy issued.

© Washington National

Washington National Insurance Company
Home Office: 11825 N. Pennsylvania St., Carmel, Indiana 46032-4555
Telephone: 1-800-888-4918

Conditional Receipt

All premium checks must be made payable to the Company. Do not make check payable to the agent or leave the payee blank.

Received from __________________________the sum of $_________which has been tendered as payment of the first ________premium for the policy/certificate which has been applied for with_____________(mode).

Washington National Insurance Company. It is understood that, if issued, the policy will be in force as of the effective date shown in the policy/certificate. If the application is declined by the Company, no insurance shall be effective and the above payment shall be returned to the applicant.

Washington National Insurance Company

Home Office: 11825 N. Pennsylvania St., Carmel, Indiana 46032-4555
Telephone: 1-800-888-4918

OUTLINE OF COVERAGE

ACCIDENTAL DEATH AND DISEMEMBERMENT

THE POLICY PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

POLICY FORM CIC1022NE

PLEASE READ YOUR POLICY CAREFULLY: This Outline of Coverage provides a very brief description of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both You and Your insurance company. It is, therefore, important that You READ YOUR POLICY CAREFULLY!

Accidental Death and Dismemberment coverage is designed to provide, to persons insured, coverage for certain Losses resulting from a Covered Accident ONLY, subject to any limitations and exclusions contained in the Policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

BENEFITS PROVIDED UNDER THE POLICY:

Please indicate the proposed insured's choice by checking the appropriate box**:**

☐ **LEVEL 1**
☐ **LEVEL 2**

ACCIDENTAL DEATH: If an Accidental Injury causes an Insured to die within 90 days after the Covered Accident, We will pay a lump sum Accidental Death Benefit for Accidental Death, Motorized Vehicle Accident, Pedestrian Accident, or Common Carrier in accordance with the Policy.

DISMEMBERMENT: If a Covered Accident causes the Dismemberment of a finger, hand, toe, foot, arm, leg, or eye within one year after the Covered Accident We will pay a benefit in accordance with the Policy.

FRACTURE: If as part of a Covered Accident You fracture a bone and it is diagnosed and treated by a Physician within 90 days after the Covered Accident, We will pay a benefit in accordance with the Policy. If the fracture requires surgical incision We will pay in accordance with the Policy.

DISLOCATION: If as part of a Covered Accident You dislocate a joint and it is diagnosed and treated by a Physician within 90 days after the Covered Accident, We will pay a benefit in accordance with the Policy. If the dislocation requires surgical incision to relocate the joint, We will pay in accordance with the Policy.

LACERATION: If as part of a Covered Accident You are lacerated and Your laceration is repaired with sutures by a Physician within 72 hours after the Covered Accident, We will pay in accordance with the Policy.

INJURIES REQUIRING SURGERY:

EYE INJURY: If as part of a Covered Accident You injure Your eye and eye surgery is performed due to the Covered Accident by a Physician within 90 days after the Covered Accident, We will pay in accordance with the Policy.

TENDON AND LIGAMENT: If as part of a Covered Accident You tear, sever or rupture Your tendon or ligament and have the injured tendon or ligament repaired through surgical incision by a Physician within 90 days after the Covered Accident, We will pay in accordance with the Policy. If the dislocation or fracture benefit is payable due to the same Covered Accident this benefit is not payable.

RUPTURED DISC: If as part of a Covered Accident You rupture a disc in Your spine and receive treatment for the rupture from a Physician within 60 days after the Covered Accident, and have the rupture repaired through surgical incision by a Physician within one year after the Covered Accident, We will pay in accordance with the Policy. The amount payable will be based on the length of time You have been insured under the Policy on the date Your Covered Accident occurred.

TORN CARTILAGE: If as part of a Covered Accident You tear cartilage and receive treatment for the torn cartilage from a Physician within 60 days after the Covered Accident and have the torn cartilage repaired through surgical incision by a Physician with one year after the Covered Accident, We will pay in accordance with the Policy. The amount payable will be based on the length of time You have been insured under the Policy on the date Your Covered Accident occurred.

HERNIA: If as part of a Covered Accident You suffer a hernia and receive treatment for the hernia from a Physician within 60 days after the Covered Accident, and have the hernia repaired through a surgical incision by a Physician within one year after the Covered Accident, We will pay in accordance with the Policy. The amount payable will be based on the length of time You have been insured under the Policy on the date Your Covered Accident occurred. If Your hernia is a herniated disc, We will pay the ruptured disc benefit in lieu of the hernia benefit.

PARALYSIS: If as part of a Covered Accident Your injury causes paraplegia or quadriplegia which is diagnosed by a Physician within 90 days after the Covered Accident, We will pay in accordance with the Policy. If you also die as a result of the same Covered Accident, We will reduce the Accidental Death benefit by the amount paid under the paralysis benefit.

BURN: If as part of a Covered Accident You are burned and Your burns are treated by a Physician within 72 hours after the Covered Accident, We will pay in accordance with the Policy. Benefits are not payable for first degree burns.

HOSPITAL CONFINEMENT: If as part of a Covered Accident You are hospital confined, We will pay in accordance with the Policy.

INTENSIVE CARE UNIT: If as part of a Covered Accident You are confined to an intensive care unit, we will pay in accordance with the Policy. This benefit is payable for up to 15 days per Covered Accident.

EMERGENCY ROOM SERVICES: If as part of a Covered Accident You are admitted to an emergency room within 72 hours of the Covered Accident, we will pay in accordance with the Policy.

AMBULANCE: If as part of a Covered Accident You are transported by ambulance to a Hospital within 72 hours, We will pay in accordance with the Policy.

PHYSICIAN'S OFFICE VISIT BENEFIT: If due to a Covered Accident You visit a Physician's office for which charges are made, We will pay in accordance with the Policy. This benefit is limited to 2 visits per Covered Accident.

PHYSICAL THERAPY BENEFIT: If due to a Covered Accident You have physical therapy, We will pay in accordance with the Policy. This benefit is limited to 8 therapy sessions per Covered Accident.

MEDICAL IMAGING BENEFIT: If due to a Covered Accident You have any of the following medical imaging exams CT (computerized tomography) scan, MRI (magnetic resonance imaging), EEG (electroencephalogram), We will pay in accordance with the Policy.

BLOOD AND PLASMA BENEFIT: If due to a Covered Accident You incur a Loss for receiving whole blood, plasma, red cells, packed cells or platelets, We will pay in accordance with the Policy. We will not pay for processing, administration, storage, laboratory charges, blood or blood components replaced by donors. This benefit is payable once per Covered Accident.

PROSTHESIS BENEFIT: If due to a Covered Accident for which You received benefits under the Policy You are prescribed prosthetic devices as prescribed by a Physician, We will pay in accordance with the Policy. Devices must be received within three years after the date of the Covered Accident for which we paid benefits.

TRANSPORTATION BENEFIT: If as part of a Covered Accident You requires special treatment and confinement in a Hospital for injuries sustained, We will pay in accordance with the Policy. This benefit is payable for the trip to the Hospital. The local attending Physician must prescribe the treatment, and the treatment must not be available locally. This benefit is not payable for transportation to any hospital located within a 100-mile radius of the site of the Accident or residence of the Insured. Ambulance or air ambulance transportation is only payable under the Ambulance benefit. This benefit is payable for up to three trips per calendar year per Insured.

FAMILY LODGING BENEFIT: If as part of a Covered Accident, when the Insured must travel more than 100 miles from their residence to be confined in a Hospital because treatment for injuries sustained in a Covered Accident are not available locally, We will pay in accordance with the Policy for one hotel/motel room for the member(s) of their Immediate Family who accompanied the Insured. This benefit is only payable during the Insured's Period of Confinement. The local attending Physician must prescribe the treatment. This benefit is payable up to 30 days per Covered Accident. The Hospital and hotel/motel must be more than 100 miles from the residence of the Insured.

Please indicate the proposed insured's choice by checking the appropriate box, if any. The Disability benefits are only available for the Policyowner:

☐ **OFF-THE-JOB ACCIDENT TOTAL DISABILITY BENEFIT**

☐ **24 HOUR ACCIDENT SHORT TERM DISABILITY BENEFIT**

OFF-THE-JOB ACCIDENT TOTAL DISABILITY BENEFIT: The Policyowner will be eligible for this benefit, if employed at least 18 hours per week at the time the Off-The-Job Covered Accident occurs and if, as the result of Accidental Injury, the Policyowner is:

- Totally Disabled within 90 Days of the Covered Accident;
- not engaged in any employment or occupation for pay, benefit, or profit; and,
- being cared for on a regular basis (at least monthly) by a Physician. This requirement is waived if the Physician states that maximum recovery has been reached and continued future treatment is of no benefit.

If the eligible Policyowner is not Totally Disabled for a full month, We will pay benefits for each full Day of Total Disability during the Policyowner's eligibility for this benefit. Daily benefits will be paid at the rate of 1/30 of the monthly amount.

If the Policyowner becomes Totally Disabled again due to the same type of bodily injury within six (6) months of the end of a period during which the Policyowner was Totally Disabled, We will treat this disability as the same disability. The maximum benefit period for a covered disability is 12 months.

We will pay only one disability benefit for a period of Total Disability even if the disability is caused by more than one Covered Accident.

This benefit is guaranteed renewable until the Policyowner's attainment of age 70. At age 70 this benefit will end.

24 HOUR ACCIDENT SHORT TERM DISABILITY BENEFIT: The Policyowner will be eligible for this benefit, if employed at least 18 hours per week at the time the Covered Accident occurs and if, as the result of an Accidental Injury, the Policyowner is:

- Totally Disabled within 90 Days of the Covered Accident;
- not engaged in any employment or occupation for pay, benefit, or profit; and,
- being cared for on a regular basis (at least monthly) by a Physician. This requirement is waived if the Physician states that maximum recovery has been reached and continued future treatment is of no benefit.

We will pay this benefit beginning with the first full Day of the Policyowner's total disability.

If the eligible Policyowner is not Totally Disabled for a full month, We will pay benefits for each full Day of Total Disability during the Policyowner's eligibility for this benefit. Daily benefits will be paid at the rate of 1/30 of the monthly amount.

If the Policyowner becomes Totally Disabled again due to the same type of bodily injury within six (6) months of the end of a period during which the Policyowner was Totally Disabled, We will treat this disability as the same disability. The maximum benefit period for a covered disability is 12 months.

We will pay only one disability benefit for a period of Total Disability even if the disability is caused by more than one Covered Accident.

This benefit is guaranteed renewable until the Policyowner's attainment of age 70. At age 70 this benefit will end.

LIMITATIONS AND EXCLUSIONS:

You will be eligible for benefits under the Policy if: You have a Covered Accident; You incur a Loss while You are insured under the Policy; and, Your Loss is not excluded by name or specific description in the Policy.

We will not pay benefits for Loss contributed to, caused by, or resulting from Your:

FLYING: Operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft including those which are not motor-driven.

HAZARDOUS ACTIVITIES: Hang-gliding, bungee jumping, parachuting, sailgliding, parasailing, parakiting, or mountaineering.

ILLEGAL ACTS: We shall not be liable for any Loss to which a contributing cause was Your commission of or attempt to commit a felony or to which a contributing cause was Your being engaged in an illegal occupation.

INTOXICATION: Being legally intoxicated, or so intoxicated that mental or physical abilities are seriously impaired, being under the influence of any illegal drugs, or being under the influence of any narcotic, unless such narcotic is taken under the direction of and as directed by a Physician.

RACING: As a rider in or driving any motor-driven vehicle in a race, stunt show or speed test; or while testing any vehicle on any racecourse or speedway.

SELF-INFLICTED INJURIES (SANE OR INSANE): Injuring or attempting to injure Yourself intentionally, regardless of mental capacity.

SICKNESS: Having any disease, bodily or mental illness, or degenerative process. We also will not pay benefits for any related medical treatments or diagnostic procedures.

SPORTS: Participating in any sporting event for pay or prize money.

SUICIDE (SANE OR INSANE): Committing or attempting to commit suicide, regardless of mental capacity.

TRAVEL: Being in an Accident which occurs more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas and the Virgin Islands, Bermuda and Jamaica, except under the Accidental Death Benefit.

WAR/MILITARY SERVICE: War or any act of war, declared or not, or participating in or contracting with the armed forces (including Coast Guard) of any country or international authority. We will return, at Your request, the prorated Premium paid for You for any period You are not insured by the Policy while You are in such service.

SUMMARY OF CLAIMS DETERMINATION PROCESS:

As provided for in the Eligibility for Benefits and the Limitations and Exclusions sections of Your Policy, the following steps are taken in order to determine eligibility under any claim filed: (1) determine when the claim was incurred, and whether the loss is covered by the Policy. This step may require the collection of medical records, a death certificate, autopsy findings from a medical examiner or coroner, and information regarding medical history from Physicians, Hospitals, other insurance companies, government agencies and medical records copying services; (2) determine if the claim was incurred at a time when Your coverage was in force, or during a lapse in coverage; and (3) determine if any Policy exclusions exist for the claim.

RENEWABILITY OF THE POLICY:

The Policy is continuously renewed by the payment of Premiums when due. However, disability benefits are guaranteed renewable only until age 70, if included.

PREMIUM:

Your initial premium depends on the optional benefits You selected. We reserve the right to change premium rates upon written notice at least 31 days before the change is to become effective.

OPTIONAL RIDERS: Please indicate the proposed insured's choices by checking the appropriate box(es).

☐ **SICKNESS DISABILITY RIDER:**
The Policyowner will be eligible for this benefit, if employed at least 18 hours per week at the time the Sickness is diagnosed and if, as the result of Sickness, the Policyowner is**:**
- Totally Disabled;
- not engaged in any employment or occupation for pay, benefit, or profit; and,
- being cared for on a regular basis (at least monthly) by a Physician. This requirement is waived if the Physician states, that maximum recovery has been reached and continued future treatment is of no benefit.

The benefit contains an Elimination Period of 14 days for each Sickness. This means that We will not pay benefits for the first 14 days of Your Total Disability.

If the Policyowner is not Totally Disabled for a full month, We will pay benefits for each full Day of Total Disability during the Policyowner's eligibility for this benefit. Daily benefits will be paid at the rate of 1/30 of the monthly amount.

If the Policyowner becomes Totally Disabled again due to the same Sickness within six (6) months of the end of a period during which the Policyowner was Totally Disabled, We will treat this disability as the same disability. The maximum benefit period for a covered disability is 12 months. We will pay only one Total Disability Benefit during a period of Total Disability even if the disability is caused by more than one Sickness.

☐ **PUBLIC SAFETY RIDER**

The Policyowner only is eligible for this benefit if he/she receives a gunshot wound from a conventional firearm while working in the line of duty as a public safety officer and within the course and scope of duty and within 24 hours of the shooting receives treatment for the wound from a physician at a hospital, we will pay $2,000.

☐ **WAIVER OF PREMIUM RIDER**

When the Policyowner is Totally Disabled as determined under the Policy or the Sickness Disability Rider (if attached to the Policy), We will waive the Premium for the period of disability. We will waive the Premium for no longer than a continuous period of Total Disability and for no longer than the maximum period of 12 months.

☐ **PHYSICIAN'S OFFICE ADDITIONAL BENEFITS RIDER**

When an Insured person visits a Physician's Office due to a Covered Accident this Rider will pay an additional benefit for each Covered Accident: (1) $50 when the Physician's Office Visit benefit and other Policy benefits are payable; or, (2) $200 when the Physician's Office Visit benefit is the only Policy benefit payable. We will only pay this benefit once per Covered Accident for each Insured.

THIS OUTLINE OF COVERAGE IS A BRIEF SUMMARY OF THE BENEFITS PROVIDED. PLEASE CONSULT THE POLICY ITSELF TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

PLEASE RETAIN THIS OUTLINE OF COVERAGE FOR YOUR RECORDS.

Policy form: CIC1022NE

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