

Washington National Insurance Company

Application to: Washington National Insurance Company

Home Office: 11825 N. Pennsylvania St., Carmel, Indiana 46032-4555

Policy Number to be Converted:

Applicant's Name (Please Print: First, Middle Initial, Last)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Age	Social Security Number
Spouse's Name (If Family Coverage)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Age	Phone Number ()

Applicant's Address	Number and Street	City	County	State	Zip Code
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Children's Name(s) (Must Meet Policy Definition Requirements)

Employer's Name or Group/Association Name (If Payroll Deduction)	Section	Department #	Occupation
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Please indicate below the type of insurance applied for and answer all applicable questions.

Has anyone to be insured under this policy:

- **ever had, been treated for, or been diagnosed as having: any heart disease; a heart condition; angina or a heart attack; any disorder; disease or abnormality of the coronary arteries; arteriosclerosis; chronic disease of the pericardium; diabetes; transient ischemic attack; stroke, whether or not resulting in paralysis?** Yes No
 If "yes," please indicate name(s) of person(s), the disease or condition diagnosed or treated, medication prescribed and complete appropriate Exclusion Rider: _____
- **for any of the above conditions, within the last year, been advised by a medical practitioner to be hospitalized, or to have any diagnostic test or surgery which has not been completed?** Yes No
 If "yes," please indicate name(s) of person(s) and complete appropriate Exclusion Rider: _____
- **ever had, been treated for, or diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?** Yes No
 If "yes," please indicate name(s) of person(s) and complete appropriate Exclusion Rider: _____

Does this policy replace any insurance you now have with another company? Yes No

Type(s) of Insurance			Mode of Payment		Premium Total	
Heart (KH) <input type="checkbox"/> Applicant Only <input type="checkbox"/> Applicant & Children <input type="checkbox"/> Applicant & Family <input type="checkbox"/> Choice A <input type="checkbox"/> Choice B: <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2 <input type="checkbox"/> Choice C: <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2	First Occurrence Rider <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> _____ Choose One: <input type="checkbox"/> Cash Value <input type="checkbox"/> Benefit Builder <input type="checkbox"/> None <input type="checkbox"/> _____	Intensive Care (IS/IT) <input type="checkbox"/> Policy Rider <input type="checkbox"/> Applicant Only <input type="checkbox"/> Applicant & Family Base <input type="checkbox"/> 300 <input type="checkbox"/> 550 <input type="checkbox"/> _____ Additional Benefits <input type="checkbox"/> 100/50 <input type="checkbox"/> 200/100 <input type="checkbox"/> _____	<input type="checkbox"/> Payroll Deduction <input type="checkbox"/> Federal Employee <input type="checkbox"/> Employee/Non-Payroll <input type="checkbox"/> Association <input type="checkbox"/> Direct	<input type="checkbox"/> Monthly <input type="checkbox"/> _____ <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> _____ <input type="checkbox"/> Monthly (Automatic Deduction) Complete authorization <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual	Heart \$ _____ First Occurrence \$ _____ Intensive Care \$ _____ _____ \$ _____ Total \$ _____ Amount Collected \$ _____	

Do you give Washington National Insurance Company permission to use your name only for marketing purposes? Yes No

Section 125 Plan: Yes No

Special Instructions

Applicant's Statement: I have read, or have had read to me, the completed application; the above representations are true to the best of my knowledge and belief. I understand that:

- any false statements or misrepresentations in this application may result in loss of insurance;
- the agent has no authority to approve the application, change the policy or waive any policy provisions;
- no insurance will be effective until the date stated in my policy and until all eligibility requirements are met; and,
- (for ages 65 and above) I have received the booklet containing insurance advice for people eligible for Medicare.

Authorization: I hereby authorize any legally licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person, that has any medical or non-medical record or knowledge of me, or any members of my family for whom application has been made, to give Washington National Insurance Company any such information. A photographic copy of this authorization shall be as valid as the original.

Date: _____ Signature of Applicant: _____ Signed In: _____
City, State

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 signed by the applicant.

Date: _____ Signature of Agent: _____ Agent #: _____ Agency: _____