Washington National℠

Application book | Nebraska

Hospital Secure®

Supplemental hospital indemnity insurance

(06/11)

H2-BOOK-NE-APP

*NBAP*WNIC*HI*

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

SECTION I

Is this a reinstatement? Yes ❑ No ❑ Is this an upgrade of existing coverage? Yes ❑ No ❑
If yes to any of the above, provide existing account number:_____
Effective date:_____

SECTION II

Applicant's Name *(Please Print: First, Middle Initial, Last)*	❑ Male ❑ Female	Date of Birth	Age	Social Security Number
Spouse's Name *(If Family Insurance is Applied for)*	❑ Male ❑ Female	Date of Birth	Age	Phone Number ( )

Applicant's Address Number and Street City County State Zip Code

Employer's Name or Group/Association Name *(If Applicable)*	Section	Department #	Occupation

SECTION III

Please indicate below the type of insurance applied for and answer all of the following health questions. If you answer "yes" to any of the health questions 1 through 6, the person(s) named will be completely excluded from insurance.

1. Is anyone to be insured under the policy currently confined to a hospital or nursing home, or has a physician recommended such confinement? ❑ Yes ❑ No

2. Has anyone to be insured under this policy ever been treated for or diagnosed by a physician as having: ❑ Yes ❑ No
   - Alzheimer's Disease
   - Dementia
   - Insulin Dependent Diabetic
   - Kidney Disease (not including kidney stones)
   - End Stage Renal Disease
   - Systemic Lupus
   - Uncorrected Congenital Heart Defect (excluding mitral valve prolapse)
   - Organ Transplant

3. In the past 10 years has anyone to be insured 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

4. Within the past 10 years has anyone to be insured under this policy ever been treated for or diagnosed by a physician as having any internal cancer, or skin cancer (except basal cell cancer)? ❑ Yes ❑ No

5. Within the past 24 months has anyone to be insured under this policy been confined in a Hospital, had outpatient surgery, received medical treatment in an emergency room, or missed five consecutive days of work for any of the following: ❑ Yes ❑ No
   - Angina (heart-related chest pain)
   - Transient Ischemic Attack or Carotid Artery Disease
   - Heart Disease, Heart attack or Surgery
   - Stroke
   - Congestive Heart Failure
   - Cerebral Vascular Insufficiency
   - Peripheral Vascular Disease
   - Parkinson's Disease
   - Crohn's Disease or Ulcerative Colitis
   - Emphysema or Asthma
   - Sickle Cell Anemia
   - Liver Disease or Disorder (excluding Hepatitis A)
   - Type II Diabetes
   - Chronic Obstructive Pulmonary Disease
   - Hypertension
   - Multiple Sclerosis
   - Epilepsy

6. Is anyone to be insured under this policy currently pregnant? ❑ Yes ❑ No

   List name(s) of person(s) answering "Yes" to any question 1 through 6._____
   _____
   has answered "Yes" to one or more of the above questions. This person(s) will not be covered under the policy.

7. Does this insurance replace any insurance anyone to be insured now has with any other company? ❑ Yes ❑ No
   If "yes," please complete the "Notice to Applicant" form.

8. Does anyone to be insured under this policy have other insurance which pays benefits for each day hospitalized\hospital confinement? ❑ Yes ❑ No
   If "yes," please complete the back of the application.

Applicant signature here ➤

Agent signature here ➤

SECTION IV Type(s) of Insurance

HOSPITAL INDEMNITY	RIDERS
❑ Individual ❑ Individual plus child(ren) ❑ Individual plus spouse ❑ Family Choose Plan: ❑ Plan A ❑ Plan B Choose Hospital Confinement Benefit: ❑ $1,000 ❑ $2,000 ❑ $1,500 ❑ $2,500 If you are applying for insurance on any dependent children, please complete the back of application.	❑ Hospitalization Daily Benefit Rider Choose the Daily Benefit: ❑ $100 ❑ $200 ❑ $300 ❑ Pet Boarding Rider

SECTION V Mode of Payment	Premium Total
❑ Monthly Bank Draft Direct Bill Options: ❑ Semi-Annual ❑ Annual Payroll Bill Options: ❑ Monthly payroll deduction ❑ Credit Union _____ Account Number ❑ Other payroll:_____ ❑ Section 125	Hospital Indemnity $_____ Hospitalization Daily Benefit Rider $_____ Pet Boarding Rider $_____ Optional Rider $_____ Total $_____ Amount Collected $_____ ❑ Draft initial premium payment (an "authorization to draft initial premium" form must be completed.) ❑ Check remitted with application *Please make check payable to: Washington National Insurance Company

Special Instructions

SECTION VI: Applicant's Statement: I have completed or have had the agent complete the application; all representations are true and complete to the best of my knowledge and belief. I understand that any false statements or misrepresentations in this application may result in loss of coverage 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 coverage 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.

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 maybe guilty of insurance fraud.

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 coverage applied for, including any pre-existing conditions. I hereby 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:_____

Agent's E-mail Address:_____

Agent's Phone Number:_____

❑ Mail to Policyholder ❑ Mail to Agent

Please Indicate the Dependent Children for Whom Insurance is Being Applied for* (Please PRINT)
(Children must meet policy eligibility requirements.)

NAME	RELATIONSHIP	DATE OF BIRTH	NAME	RELATIONSHIP	DATE OF BIRTH

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

Other Insurance** (Please PRINT)

NAME OF PERSON INSURED	NAME OF COMPANY	TYPE OF INSURANCE	DAILY HOSPITAL AMOUNT(S)

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

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. 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 to opt-out of Affiliate sharing, nonaffiliated company sharing or both. If you previously opted out of Affiliate sharing, your election is effective for 5 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 <u>not</u> 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. We may share your PII with nonaffiliated companies for purposes that are allowed by law.

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

Vermont Residents
For marketing purposes, we will only disclose your name, contact information and information about your transactions with us to non affiliated 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 non affiliated 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 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 for correction 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 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 violation. 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 in writing to you. 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.

Additional Privacy Standards for Health Insurance

We are subject to additional privacy standards for health insurance. 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.

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

- **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 medical information with your health care providers in connection with settling your claims. Also, we may use your medical information 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 US 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 a 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 life 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 life 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 800-525-7662 or write to us at P.O. Box 2031, Carmel, IN 46082-2031.

This notice is effective January 1, 2011.

✂- -

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 you 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, Colonial Penn Life Insurance Company, Conseco Life Insurance Company, Conseco Life Insurance Company of Texas, Washington National Insurance Company. Bankers Conseco Life Insurance Company is a New York licensed insurance company.

To be obtained before insurance is issued

Authorization to Obtain Medical Records

Pursuant to the HIPAA Privacy Rule

▶ I. MY INFORMATION—the individual who is the subject of the information

Printed name	Date of birth	Social Security number

Address	City	State	ZIP code

▶ II. DISCLOSING PARTY—the party or parties authorized to release information about me

Any physician or other healthcare provider, hospital, clinic, medical facility, clinical lab, pharmacy, pharmacy benefit manager or pharmacy-related organization, insurance company or health plan, Social Security Administration, governmental agency, MIB Inc., or my employer

▶ III. DESCRIPTION OF MY INFORMATION AUTHORIZED FOR RELEASE

Any information related to my past, present or future health condition(s), medical care or treatment, which includes information about mental health, communicable disease, HIV/AIDS and substance abuse, but excludes psychotherapy notes

▶ IV. PURPOSE OF AUTHORIZATION—how my information will be used by the receiving party

To determine my eligibility for coverage and administer benefits under a policy or certificate of insurance

▶ V. DURATION OF AUTHORIZATION

Twenty-four (24) months from the date written below

▶ VI. RECEIVING PARTY—the party authorized to receive information about me

Washington National Insurance Company

▶ VII. APPROVAL—signed and dated by me or my legal representative

Do not sign this form until you review the important information on the other side.

Print name of person signing	Relationship (if signed by legal representative*)

Signature	Date

**Legal representatives must provide documentation of legal authority*

Washington National Insurance Company
11825 N. Pennsylvania Street, Carmel, IN 46032
Phone: (800) 525-7662 Fax: (800) 757-6324

(06/11) 140022
MEDAUTH-FORM-PRE

Applicant copy

To be obtained before insurance is issued

Authorization to Obtain Medical Records

Pursuant to the HIPAA Privacy Rule

Important information about this Authorization to Obtain Medical Records

- I understand this authorization is required to determine my eligibility for coverage and benefits under a policy or certificate of insurance.

- Refusing to sign this authorization does not affect my ability to obtain medical treatment, but it may prevent coverage from being issued or being able to determine when benefits are payable under the terms of my coverage.

- I understand that I can revoke this authorization at any time, except to the extent it has been relied upon, by sending a written revocation to:

  Washington National Insurance Company
  P.O. Box 2024
  Carmel, IN 46082-2024

- I understand that if the person or organization I authorize to receive information described in this authorization is not subject to federal health information privacy laws, then such information could be re-disclosed and would no longer be protected by these laws.

- I understand that I have a right to a copy of this authorization.

- I understand that a photocopy or facsimile of this authorization is as valid as the original.

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11825 N. Pennsylvania Street, Carmel, IN 46032
Phone: (800) 525-7662 Fax: (800) 757-6324

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▶ II. DISCLOSING PARTY—the party or parties authorized to release information about me

Any physician or other healthcare provider, hospital, clinic, medical facility, clinical lab, pharmacy, pharmacy benefit manager or pharmacy-related organization, insurance company or health plan, Social Security Administration, governmental agency, MIB Inc., or my employer

▶ III. DESCRIPTION OF MY INFORMATION AUTHORIZED FOR RELEASE

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Washington National Insurance Company
11825 N. Pennsylvania Street, Carmel, IN 46032
Phone: (800) 525-7662 Fax: (800) 757-6324

(06/11) 140022
MEDAUTH-FORM-PRE

Home Office copy

To be obtained before insurance is issued

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Washington National Insurance Company
11825 N. Pennsylvania Street, Carmel, IN 46032
Phone: (800) 525-7662 Fax: (800) 757-6324

(06/11) 140022
MEDAUTH-FORM-PRE

Home Office 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)

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.

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_____
Date

_____
Applicant's Signature

_____
Date

_____
Spouse's Signature (if applying)

Home Office Copy

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 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

HOSPITAL INDEMNITY COVERAGE

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

POLICY FORM CIC1019NE

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!

Hospital confinement indemnity coverage is designed to provide, to persons insured, coverage in the form of a fixed amount for hospitalization resulting from a Covered Accident or Covered Sickness, subject to any limitations set forth in the Policy. Coverage is not provided for any benefits other than the fixed indemnity for hospital confinement and any additional benefits as described below.

BENEFITS PROVIDED UNDER THE POLICY:

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

☐ **PLAN A**
☐ **PLAN B**

HOSPITAL CONFINEMENT BENEFIT (available on Plan A and Plan B): We will pay the benefit amount as selected on your application per Hospital Confinement when You are confined as an inpatient to a Hospital for a Covered Sickness or a Covered Accident.

If You are re-confined within 30 days, then the later period will be considered a continuation of the prior Period of Confinement. If re-confinement occurs more than 30 days later, We will treat the later Hospital Confinement as a new Period of Confinement.

OUTPATIENT SURGICAL BENEFIT (available on Plan B only): When an Insured has a surgery on an outpatient basis for a Covered Sickness or a Covered Accident We will pay $100. This benefit is only payable once per day regardless of the number of outpatient surgical services provided during that outpatient surgery.

This benefit is limited to 2 per individual per Calendar Year. If this is an Individual plus Child(ren) or an Individual plus Spouse Policy this benefit is limited to 2 per individual per Calendar year with a maximum of 4 per Calendar Year. If this is a Family Policy this benefit is limited to 2 per individual per Calendar year with a maximum of 6 per Calendar Year.

PHYSICIAN'S OFFICE VISIT BENEFIT (available on Plan B only): When an Insured person visits a Physician's office for which a charge is made We will pay $30 per visit. This benefit covers office visits for a Covered Accident, a Covered Sickness and routine wellness exams.

This benefit is limited to 3 per individual per Calendar Year. If this is an Individual plus Child(ren) or an Individual plus Spouse Policy this benefit is limited to 3 per individual per Calendar year with a maximum of 6 visits per Calendar Year. If this is a Family Policy this benefit is limited to 3 per individual per Calendar year with a maximum of 9 visits per Calendar Year.

EMERGENCY ROOM BENEFIT (available on Plan B only): When an Insured is admitted to an Emergency Room for a Covered Sickness or a Covered Accident We will pay $100. This benefit is limited to 2 visits per Calendar Year. Admission to the Emergency Room for a Covered Accident must occur within 72 hours of the Covered Accident.

If an Insured is traveling and is more than 100 miles from their residence, We will pay an additional $100 when an Insured is admitted to an Emergency Room for a Covered Sickness or a Covered Accident when admission is within 72 hours of the Covered Accident.

This benefit is limited to 2 per individual per Calendar Year. If this is an Individual plus Child(ren) or an Individual plus Spouse Policy this benefit is limited to 2 per individual per Calendar year with a maximum of 4 per Calendar Year. If this is a Family Policy this benefit is limited to 2 per individual per Calendar year with a maximum of 6 per Calendar Year.

LIMITATIONS AND EXCLUSIONS:

You will be eligible for benefits under the Policy if: Your Covered Sickness begins or Covered Accident occurs while You are insured under this Policy; You incur a Loss after the 30-day waiting period due to a Covered Sickness; You incur Loss for a Covered Accident after the Effective Date of coverage; while You are insured under this Policy; and, Your Loss is not excluded by name or specific description in this Policy. If an Insured is hospitalized during the first 30 days of coverage under this Policy, benefits for that Covered Sickness will only be provided 12 months after the Insured's Effective Date of coverage.

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

COSMETIC/PLASTIC SURGERY: Surgery that is not for the diagnosis or treatment of Covered Sickness or Covered Accident based upon generally accepted medical practice and is not medically necessary. The following procedures are not covered under any circumstances, even if performed for diagnosis or treatment of a Covered Sickness or Accident or medically necessary. Abdominoplasty (tummy tuck); Mammaplasty (breast enlargement); Rhinoplasty (nose job); or Suction Assisted Lipectomy (liposuction). Complications from any Cosmetic/Plastic surgery are not covered.

DENTAL PROCEDURES: Treatment for dental care or dental procedures, unless treatment is the result of a Covered Accident.

ELECTIVE SURGERY: Surgery that is not for the diagnosis or treatment of a Covered Sickness or Covered Accident based upon generally accepted medical practice and is not medically necessary. Gastric Bypass Surgeries are not covered under any circumstances, even if performed for diagnosis or treatment of a Covered Sickness or Accident or medically necessary, Voluntary abortion (except where the Insured or the Insured's spouse would be endangered if the fetus were carried to term or where medical complications have arisen from abortion); or Sex changes. Complications from any Elective surgery are not covered.

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.

ILLEGAL ACTS: Participating or attempting to participate in an illegal act, or working at an illegal job.

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

MENTAL DISORDER: Having a behavioral or psychological disorder, disease, or syndrome, without demonstrable organic origin.

NEWBORN CARE: We will not pay for a separate charge made for the newborns stay in a nursery as a result of a normal delivery.

OBSERVATION UNIT: Any services provided or charges made for an Insured while in an Observation Unit.

PREGNANCY: Normal pregnancy. Loss due to complications of pregnancy will be paid the same as for any other Covered Sickness. A Cesarean is not considered a complication of pregnancy.

PREGNANCY OF A DEPENDENT CHILD: A pregnancy of a dependent child will not be covered.

PRE-EXISTING CONDITIONS: Having any Pre-Existing Condition not otherwise excluded by name or specific description. Benefits will not be paid for losses related to such Sickness, Accidental Injury or condition which occurs during the first twelve (12) months after the Effective Date of Your coverage.

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

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

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

SUBSTANCE ABUSE: Alcoholism, drug abuse, or chemical dependency.

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

TRAVEL/LOCATION: Being more than 40 miles outside the territorial limits of the United States, Canada, and Puerto Rico.

VISION PROCEDURES: Vision exams or vision procedures, unless treatment is the result of a Covered Accident or a Covered Sickness.

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 this Policy while Your 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, and not during the eligibility period or during a lapse in coverage; and (3) determine if any Policy exclusions exist for the claim.

RENEWABILITY OF THIS POLICY:

This Policy is continuously renewed by the payment of Premiums when due up to the age of 65.

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).

☐ **HOSPITAL CONFINEMENT DAILY BENEFIT:** We will pay the benefit amount as selected on your application per day of Hospital Confinement beginning with the second day of Hospital Confinement when You are confined as an inpatient to a Hospital for a Covered Sickness or a Covered Accident.

If You are re-confined within 30 days, then the later period will be considered a continuation of the prior Period of Confinement. If re-confinement occurs more than 30 days later, We will treat the later Hospital Confinement as a new Period of Confinement.

☐ **PET BOARDING BENEFIT:** We will pay $30 per day when You board Your Pet, regardless of the number of Pets, at a Kennel due to Your Hospital Confinement for a Covered Sickness or Covered Accident. This benefit is limited to 14 days per confinement.

You may choose any Kennel You wish for care of Your Pets. By offering this Rider, We make no recommendation whatsoever as to which Kennel You may choose, and We will not be liable, beyond the benefit provided by this Rider, for any care or lack of care by any Kennel You do choose.

If You are re-confined within 30 days, then the later period will be considered a continuation of the prior Period of Confinement. If re-confinement occurs more than 30 days later, We will treat the later Hospital Confinement as a new Period of Confinement.

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 Series: CIC1019NE

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