lifesecure™

INDIVIDUAL

LIFESECURE INSURANCE COMPANY

Critical Illness Insurance
Application & Regulatory Forms

Instructions for Agent:

The Application must be entered online via LifeSecure's website.

- Enter the Application information into the LifeSecure Agent Portal at ***www.YourLifeSecure.com***
- Fax the signed paper Application to **1.866.582.7706**

The following forms must be left with your client:

- Notices to the Applicant
- Outline of Coverage

In addition, ***a Medicare handbook*** should be provided to applicants who are eligible for Medicare by age.

Please refer to the ***"Agent Guide for Selling Ancillary Benefits to Individual and Worksite Clients"*** for additional information regarding our application process.

For use in the state of: Nebraska

LifeSecure Insurance Company
10559 Citation Drive, Suite 300
Brighton, MI 48116

Critical Illness Insurance Individual Application

Application for:
☐ New Coverage ☐ Reinstatement *
☐ Increase of Benefits*
☐ Replacement of existing LifeSecure policy*
* LifeSecure Policy Number: _____

Section 1 | Primary Applicant Information |

Print clearly – Use black or blue ink.

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

_____ _____ _____ _____
Name (First) (MI) (Last) (Suffix)

_____ _____
Street Address (Post Office Box Not Allowed) Apt #

_____ _____ _____
City State Zip Code

_____ _____-_____-_____ _____
Date of Birth (mm/dd/yyyy) Social Security Number (or ITIN) Telephone

Gender: ☐ Male ☐ Female

Within the last 12 months have you used any form of tobacco or nicotine product including electronic cigarette?
☐ Yes ☐ No

How would you like to receive your policy: ☐ Paper copy via Mail ☐ Electronic

_____ (E-mail address cannot be the agent's E-mail)
E-mail Address (required for policy delivery to agent or electronic policy delivery)

Caution: If your answers on this application are incorrect or untrue, LifeSecure may deny benefits or rescind your coverage.

Section 2 | Coverage Selection |

Who is applying for Coverage: ☐ Self-only ☐ Self plus Spouse

Benefit Amount: ($5,000 to $50,000 in $5,000 increments)**: $** _____

- Each Dependent Child is automatically covered with a $2,500 Benefit Amount.

For an Increase of Benefits, please enter the requested Benefit Amount only.

Spouse/Domestic Partner Information

_____ _____ _____ _____
Name (First) (MI) (Last) (Suffix)

_____ _____-_____-_____
Date of Birth (mm/dd/yyyy) Social Security Number (or ITIN)

Gender: ☐ Male ☐ Female

Within the last 12 months, have you used any form of tobacco or nicotine product including electronic cigarette?
☐ Yes ☐ No

Section 3 | Insurability Information |

Applicant: Height: ____ ft. _____ in. Weight _____lbs.

Spouse/DP: (if applying): Height: ____ ft. ____ in. Weight _____lbs.

		Self	**Spouse/ DP**
1.	Within the past 10 years, have you ever been diagnosed with, treated for, or received medical advice from a healthcare professional for any of the following conditions: heart disease, chronic lung disease, major organ transplant, coronary artery disease, heart attack, angina, angioplasty, stent replacement or bypass surgery, atrial fibrillation, valvular heart disease, carotid artery disease, cerebral vascular disease, brain aneurysm, stroke (CVA) or transient ischemic attack (TIA), peripheral vascular disease, cancer (including, but not limited to, carcinoma, sarcoma, Hodgkin's Disease tumor, Leukemia, lymphoma, in situ, malignant tumor, melanoma and basal cell or squamous cell carcinoma), liver disease, impaired kidney function, diabetes, AIDS, HIV, ARC, or chronic obstructive pulmonary disease (COPD)?	☐Yes ☐No	☐Yes ☐No
2.	For any condition listed in question 1, within the past 2 years, have you had any abnormal diagnostic tests for which you are awaiting results or have you been advised by a healthcare professional to seek consultation with a medical professional or to undergo diagnostic testing (including self-administered) but have not done so?	☐Yes ☐No	☐Yes ☐No
3.	Within the past 5 years, have you been diagnosed with, treated for or received medical advice from a healthcare professional for alcohol or drug abuse?	☐Yes ☐No	☐Yes ☐No
4.	Are you currently receiving, or within the past 2 years, have you received or applied for Social Security Disability Income Benefits?	☐Yes ☐No	☐Yes ☐No

- If you answered "**Yes**" to any part of any part of any question in Section 3 above, **PLEASE DO NOT CONTINUE.** We regret that we cannot offer you critical illness coverage.
- If you answered **"Yes**" to any part of any question in Section 3 above for "**Spouse/DP**", we regret that we cannot offer critical illness coverage to your spouse/domestic partner.
- For applicants answering "**No**" to all of the questions, please **CONTINUE**.

Section 4 | Existing Coverage and Replacement Question |

Will this policy replace any health insurance presently in force with:

LifeSecure? ☐ Yes ☐ No
Any other Company? ☐ Yes ☐ No

If "Yes", provide details:

Company Name: _____

Company Address: _____

-OR-

Individual or Group Policy Number: _____

If "Yes", please also submit the required Notice to Applicant Regarding Replacement of Accident and Health Insurance Form.

Section 5 | Premium Payment Authorization |

Complete this section to authorize your preferred premium payment method.

Premium Amount: ☐ Monthly $_____ ☐ Quarterly $_____
☐ Semi-Annually $_____ ☐ Annually $_____

☐ **Direct-Billing (Mail)**

Select one payment mode: ☐ annually ☐ semi-annually ☐ quarterly

OR

☐ **Electronic Funds Transfer (EFT)**

Select one payment mode: ☐ annually ☐ semi-annually ☐ quarterly ☐ monthly

EFT Agreement:
I authorize LifeSecure to electronically withdraw money from my account for the payment of premiums for this insurance policy. I authorize LifeSecure to continue to make these withdrawals if there is a renewal, or other change in the policy. I will compensate LifeSecure for any loss, claim, or liability caused by these withdrawals and will not hold LifeSecure responsible for any such loss, claim, or liability. This authorization will not affect the terms of the policy. Authorizing this automatic payment plan does not begin coverage under the policy. This authorization may be retracted by me or LifeSecure at any time for any reason by giving written notice. LifeSecure may retract the authorization immediately, without giving me written notice, if any debt is not paid by the authorized bank, for any reason.

Name of Bank: _____

Bank Address: _____ _____
City State

Account Type: ☐ checking ☐ savings

Routing #:_____ Account #: _____

Preferred Draft Date: _____ (1st – 28th)

Accountholder Name (if different than primary applicant) _____

X_____ _____
Accountholder Signature Date

OR

☐ **Automatic Credit Card Payment**

Select one payment mode: ☐ annually ☐ semi-annually ☐ quarterly ☐ monthly
Select Card Type: ☐ Visa ☐ MasterCard

Credit Card #: _____ Expiration Date: _____

Name as it appears on Card: _____

Preferred transaction date: _____ (1st – 28th)

X_____ _____
Cardholder Signature Date

Section 6 | Applicant Acknowledgements and Signatures |

Your signature, whether electronic or handwritten, represents your acknowledgement, acceptance and authorization of each statement. Please consider each statement carefully before signing.

Acknowledgements

I represent that all information supplied on this Application is true and complete to the best of my knowledge and belief. I understand that the policy will not take effect until my application is approved by LifeSecure and there has been no change in my health that would change the answer to any questions in my application. I agree to notify LifeSecure of any change in my medical condition while my application is pending underwriting review. This application does not provide temporary insurance. If this application is declined, any advance premium payment submitted with the application will be refunded without interest. I understand that LifeSecure will have no liability until a policy is issued to me and the first full premium for the issued policy has been paid.

I acknowledge that I have read the Notices to the Applicant regarding the Fraud Warning and the Insurance Information Practices which appear in this Application. I acknowledge that I have received an Outline of Coverage. I acknowledge receipt of the Medicare handbook published by the Centers for Medicare & Medicaid Services (if eligible for Medicare).

Authorizations

I authorize any licensed physician, healthcare professional, hospital, clinic, Veterans Administration or other medical or medically-related facility, care provider or evaluator, pharmacy or pharmacy benefit management (PBM) company, insurance company, MIB Inc. (MIB), consumer reporting agency, other organization, institution or other person or organization that has any records or knowledge of my health, prescription drug or medication history to give to LifeSecure Insurance Company, or its reinsurer(s) any such information, I authorize LifeSecure Insurance Company (LifeSecure), or its reinsurers to make a brief report of my protected health information to MIB. Such health information about me may be disclosed to LifeSecure and any representatives performing services for LifeSecure, including its agents, insurance support organizations, third-party administrators, affiliates, any reinsurers, and any consumer reporting agency such as the MIB.

I recognize that such health information shall be used to consider my insurability with LifeSecure. A photocopy of this authorization shall be as valid as the original. I agree that this authorization will be valid for 24 months from the date signed. This authorization may be revoked upon submission of a written request to LifeSecure's Privacy Office at the following address: P.O. Box 1019, Brighton, MI 48116. Any action taken by LifeSecure (or one of its representatives) before receipt of the written notice of revocation will still be valid.

Although my signature on this form is voluntary, I understand that it is required to determine my insurability and qualification to be issued an insurance policy from LifeSecure. Without my signature, I understand that my application for insurance cannot be processed. By signing, I also acknowledge that if a party or organization receiving my protected health information is not a health plan or health care provider, subject to federal health information privacy laws, then the information described may be disclosed to others and no longer be protected by such laws. However, LifeSecure does require its agents and service providers to protect the confidentiality of health information.

No producer can waive or change any receipt or policy provision or agree to issue a policy.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

The Policy provides limited benefits. Review Your Policy carefully!

CAUTION: I understand that the policy applied for will not pay benefits for any loss incurred during the first 12 months after the issue date on account of disease or physical condition which I now have or have had in the past 12 months.

All answers I have provided in this application are representations, not warranties.

Applicant Signature

I, the applicant, certify that I have read, or have had read to me, this completed Application. My signature represents my understanding and acceptance of all statements in this Applicant Acknowledgements and Signatures Section, including the Fraud Warning. I approve all my answers as recorded in this Application.

Primary Applicant

X _____ _____

Applicant's Signature **Applicant's Name (Print)**

_____

Date

I represent that I have signed the application in: _____ _____

City State

Spouse/Domestic Partner (if applying)

X _____ _____

Spouse/Domestic Partner's Signature **Spouse/Domestic Partner's Printed Name**

(if applying)

_____

Date

I represent that I have signed the application in: _____ _____

City State

Section 7 | Agent Signature |

I, the agent, certify that the applicant has read, or I have read to the applicant, the completed Application. I also certify, to the best of my knowledge and belief, that the answers contained in this Application are true, complete and correctly recorded. I have advised the applicant that any false statement or misrepresentation in the Application may result in loss of coverage under the policy.

X _____ _____

Soliciting Agent's Signature **Agent's Printed Name**

_____ _____

LifeSecure ID # **Contract Number**

_____

Date

Policy Delivery Choice

If the Applicant chose to receive his/her policy hard-copy via mail in Section 1, please designate where the policy welcome kit should be sent.

☐ Policyholder ☐ Sales Agent (can only be elected if the applicant provided their e-mail address)

Case Split Information (if applicable)

Check one box for Agent to receive policy (if applicable)

☐ Agent Name _____ % Split _____
Agent License # _____ Contract #: _____
LifeSecure ID # _____

☐ Agent Name _____ % Split _____
Agent License # _____ Contract #: _____
LifeSecure ID # _____

☐ Agent Name _____ % Split _____
Agent License # _____ Contract #: _____
LifeSecure ID # _____

_____
100%

LifeSecure Insurance Company
10559 Citation Drive, Suite 300
Brighton, MI 48116

| Notices to the Applicant |

Fraud Warning

For All States Not Listed Separately Below: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

To residents of **Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

To residents of **Arkansas, Louisiana, Rhode Island & West Virginia:** Any person who knowingly: presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

To residents of **Maryland:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

To residents of **Colorado**: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

To residents of **DC: WARNING IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.**

To residents of **Kentucky**: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

To residents of **New Mexico**: Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

To residents of **Oklahoma: WARNING** – Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

To residents of **Pennsylvania**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

To residents of **Tennessee**, **Virginia & Washington**: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

To residents of **Oregon**: Any person who, with intent to defraud, or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing misstatements which are either fraudulent or material to the interests of the insurer, may be guilty of insurance fraud.

Insurance Information Practices

To issue insurance coverage, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may, in certain circumstances, be disclosed to third parties without your specific authorization as permitted or required by law. You have the right to access and correct this information, except information that relates to a claim or civil or criminal proceeding. Upon your written request, LifeSecure will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information, and the role of insurance support organizations with regard to your information.

If you would like more information about our information practices, please write or e-mail us at:

LifeSecure Insurance Company
10559 Citation Drive, Suite 300
Brighton, MI 48116

info@YourLifeSecure.com