Print Form | Save Form

LIFESECURE INSURANCE COMPANY

Hospital Recovery Insurance

Application & Regulatory Forms

For use in the state of:

Nebraska

Instructions for Agent:

The Application must be entered on-line 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
- If coverage is being replaced:
  - a copy of the Notice to Applicant Regarding Replacement of Accident and Sickness Insurance must be left with the client, and
  - a signed copy of the form must be faxed to LifeSecure at **1.866.582.7706** in order for the policy to be issued.

In addition, *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* should be provided to applicants who are eligible for Medicare by age. The guide can be downloaded from **www.YourLifeSecure.com** under "About Our Products".

Please refer to the "Hospital Recovery & Personal Accident Agent Handbook" for additional information regarding our application process.

LIFESECURE INSURANCE COMPANY | Hospital Recovery Insurance

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

Hospital Recovery Insurance Application

Application for: ☐ New Coverage ☐ Reinstatement ☐ Increase of Benefits

Section 1 | Primary Applicant Information |

Print clearly – Use black or blue ink.

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Group Number (if applicable):_____

_____ _____ _____ _____
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 **Height** ___ ft. ___ in. **Weight** _____lbs

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

_____
E-mail Address (required for Electronic via E-mail policy delivery; cannot be the agent's e-mail address)

Federal regulations require that all persons applying for this coverage have major medical coverage (or other Minimum Essential Coverage) in force. Do you have major medical coverage (or other Minimum Essential Coverage) in force? ☐ Yes ☐ No

If you answered "**No**" to this question, **PLEASE DO NOT CONTINUE**. We regret that we cannot offer you insurance coverage at this time. If you answered "**Yes**", please **CONTINUE**.

Section 2 | Coverage Selection |

Who is Applying for Coverage:

☐ Self-only ☐ Self plus Spouse/Domestic Partner

☐ Self plus Children ☐ Self plus Spouse/Domestic Partner & Children

Daily Benefit Amount:

Enter a dollar amount between $100 and $900 (in $10 increments}

$_____

Note: If you are applying for coverage with dependents, the Daily Benefit Amount applies to each covered family member individually.

For an Increase of Benefits, please enter the requested increase amount only.

Optional Riders

Emergency Room & Ambulance Rider:	☐ Yes	☐ No
Major Diagnostic Exam Rider:	☐ Yes	☐ No
Rehabilitation Facility Rider:	☐ Yes	☐ No

Dependent Information (Do not complete if you elected Self-only coverage above.)

_____ _____ _____ _____

Spouse/Domestic Partner's Name (First) (MI) (Last) (Suffix)

_____ _____-_____-_____

Spouse/Domestic Partner's Date of Birth (mm/dd/yyyy) **Social Security Number** (or ITIN)

Spouse/Domestic Partner's Gender: ☐ Male ☐ Female **Height** _____ ft. _____ in. **Weight** _____lbs

	Children	Date of Birth	Gender	Relationship
1.	_____ **Name** (First, MI, Last)	_____ (mm/dd/yyyy)	☐ M ☐ F	_____
2.	_____ **Name** (First, MI, Last)	_____ (mm/dd/yyyy)	☐ M ☐ F	_____
3.	_____ **Name** (First, MI, Last)	_____ (mm/dd/yyyy)	☐ M ☐ F	_____
4.	_____ **Name** (First, MI, Last)	_____ (mm/dd/yyyy)	☐ M ☐ F	_____
5.	_____ **Name** (First, MI, Last)	_____ (mm/dd/yyyy)	☐ M ☐ F	_____

Section 3 | Medical Information |

		Self	Spouse/ DP	Child (ren)
1.	Has any person applying for coverage been advised in the *past 2 years* by a Licensed Health Care Practitioner to: • have surgery or therapy which would require an inpatient hospital stay which has not yet been completed, or • have diagnostic tests which have not yet been completed or for which results have not yet been received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2.	Is any person applying for coverage currently pregnant, bedridden, confined to a wheelchair, receiving home healthcare services, staying in a nursing home, or receiving medical assistance at an assisted living facility?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3.	Has any person applying for coverage been hospitalized 3 or more times in the *past 2 years*?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4.	In the *past 2 years*, has any person applying for coverage been diagnosed with, treated for, or received medical advice from a Licensed Health Care Practitioner for:			
	a. Diabetes requiring Insulin, Kidney Failure, Kidney Dialysis, Cirrhosis of the Liver, or Hepatitis C?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	b. Cancer (other than Basal Cell or Melanoma), Leukemia, Hodgkin's Disease, or Lymphoma?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	c. Congestive Heart Failure, Heart Surgery of any type, Stroke (CVA), or Transient Ischemic Attack (TIA)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	d. Emphysema, Chronic Obstructive Pulmonary Disease or the use of oxygen to assist in breathing?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	e. Alzheimer's Disease, Senile Dementia, Amyotrophic Lateral Sclerosis (ALS), Parkinson's Disease, Systemic Lupus Erythematosus, Hemophilia, or Neurological Disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	f. Having or testing positive for Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	g. Multiple Sclerosis, Muscular Dystrophy, Cerebral Palsy, or Cystic Fibrosis?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

- If you answered "**Yes**" to any part of any question in Section 3 for "**Self**", **PLEASE DO NOT CONTINUE.** We regret that we cannot offer coverage to you at this time.

- If you answered "**Yes**" to any part of any question in Section 3 for "**Spouse/DP**", we regret that we cannot offer coverage to your spouse/domestic partner at this time.

- If you answered "**Yes**" to any part of any question in Section 3 for "**Children**" AND your application includes multiple children, please identify below the specific child(ren) for whom you had checked a "Yes" answer. We regret that we cannot offer coverage to this/these specific child(ren) at this time.

  Child's Name: _____

  Child's Name: _____

  If you answered "**Yes**" to any part of any question in Section 3 for "**Children**" AND your application includes only one child, we regret that we cannot offer coverage to your child at this time.

For applicants answering "**No**" to all of the questions, please **CONTINUE**.

Section 4 | Existing Coverage and Replacement Question |

Will this policy replace any Health or Accident & Sickness Insurance presently in force with this or 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

How EFT Works: EFT is a debit service that offers a convenient way to pay your insurance premiums. LifeSecure Insurance Company (LifeSecure) will collect the insurance premiums from your bank account electronically. You do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium.

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 put the insurance policy into effect. 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 bank stated, 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**

OR

☐ **Employer List Bill**

If my employer is paying less than 100% of my premium, or if this coverage is being offered on a voluntary employee-pay-all basis, I authorize my employer to deduct my portion of the insurance premium from my payroll. I understand that if my employer stops paying my premium for any reason, I will be responsible for the premium in order to keep my policy in force.

Employee Number (if applicable)**:** _____

Payroll Frequency: _____

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 providing your signature authorization.

Acknowledgements

I represent that all information supplied on this Application is true and complete to the best of my knowledge. 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. 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 hereby authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit management (PBM) company or other medical related facility, insurance company, or other organization, institution or person 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. This authorization shall be valid for 24 months. I understand the purpose of this authorization is to allow LifeSecure Insurance Company to determine eligibility for this insurance.

Any information obtained will not be released by LifeSecure Insurance Company to any person or organization except to reinsuring companies, or other persons or organizations performing business or legal services in connection with my application or as may be otherwise lawfully required. I understand that I may cancel this authorization at any time by contacting LifeSecure Insurance Company at the address on this application. 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.

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 if any of my answers on this Application are incorrect or untrue, LifeSecure may have the right to deny benefits or rescind my policy. I understand that the policy applied for will not pay benefits for any loss incurred during the first 6 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.

I hereby attest that I have major medical health insurance or Medicare that meets the requirements of minimum essential coverage as defined by the federal Affordable Care Act.

Primary Applicant

☐ I also authorize LifeSecure to disclose my Personal Health Information (PHI) in connection with my application and the underwriting decision to my agent.

X _____ _____

Primary Applicant's Signature Date

_____

Primary Applicant's Printed Name

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

City State

Spouse/Domestic Partner (if applying)

☐ I also authorize LifeSecure to disclose my Personal Health Information (PHI) in connection with my application and the underwriting decision to my agent.

X _____ _____

Spouse/Domestic Partner's Signature (if applying) Date

_____

Spouse/Domestic Partner's Printed Name

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

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

| 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 **Arkansas, Louisiana, Maryland, 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 **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.

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