



Application book | Kansas

ACCIDENT*assure*[®]
ACCIDENTAL INJURY & DISABILITY INCOME INSURANCE

SECTION I Accident Insurance Application

Is this a reinstatement? Yes No Is this an upgrade of existing coverage? Yes No
 Are you adding a family member (spouse/child)? 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) <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/dd/yyyy) and State	Age	Social Security Number	(Area Code) Phone Number
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Spouse's Name (If applying for Spouse Insurance) (First, Middle Initial, Last)	(Spouse) <input type="checkbox"/> Male <input type="checkbox"/> Female
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Date of Birth (mm/dd/yyyy) and State	Age	Social Security Number	If applying for Child(ren) Insurance, complete Section VI.
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Applicant's Street Address

City State Zip Code

E-mail Address

Beneficiary's Full Name, Relationship to Primary Applicant and percentage, if applicable.	
1.	2.
3.	4.

SECTION III Employer Information

Employer's Name, Type of Business and SIC Code

Job Title and Duties

Hours per week worked at this job _____	Length of time employed by this employer _____ Years _____ Months	Job Class (circle one) 1 2 3 4
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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?
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)?
If "Yes", complete the appropriate information below.

Yes No

Yes No

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.

For All Disability Coverage (Only available for Primary Applicant). If the answer to any question 4 through 9 is "Yes", you are not eligible for any disability coverage.

- 3. Provide your gross monthly income from your employer as listed in Section III, Employer Information. I certify that this is my gross monthly income and understand that verification will be completed at time of claim. Gross monthly income for the purposes of this application is your regular income (pre-tax) excluding overtime, bonuses, and any incentives.
- 4. In the past 5 years have you:
 - (a) been convicted of a felony,
 - (b) been charged with operating a vehicle under the influence of alcohol or drugs,
 - (c) been charged with three (3) or more moving violations, or
 - (d) been incarcerated in a correctional institution or are currently on parole?
- 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)?
- 6. Are there any material or substantial job duties you are currently unable to perform due to sickness, maternity or injury?
- 7. In the past 12 months have you been off work for 5 or more consecutive workdays due to illness or injury (other than for normal pregnancy)?
- 8. Are you currently or have you in the past 12 months been diagnosed with, treated for, had procedures related to or prescribed medication for any of the following conditions:
 - (a) any disease or disorder of the cartilage, bone, tendon, muscles or ligaments of the knee, back, discs of the spine, neck, joints, hip or ankle including but not limited to degenerative joint disease or osteoarthritis,
 - (b) carpal tunnel syndrome,
 - (c) psoriatic arthritis or rheumatoid arthritis, or
 - (d) radiculopathy or sciatica?
- 9. In the past 5 years have you been diagnosed with, treated for or had procedures related to any of the following conditions: chronic fatigue syndrome or fibromyalgia?

\$ _____

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

<p>For 24 Hour Accident Short Term Disability Coverage (Only available for Primary Applicant). If the answer to question 10 is “Yes”, you are not eligible.</p> <p>10. Are you covered by worker’s compensation or similar law in your full time job? Similar laws include but are not limited to Railroad Retirement Act; Merchant Marine Act of 1920 also known as the Jones Act; Maritime Doctrine of Maintenance; Wages or Cure; Longshoremen’s and Harbor Worker’s Acts; State Disability Plans.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>																																																		
<p>For Sickness Disability Rider (Only available for Primary Applicant). If the answer to any question 12 through 17 is “Yes”, you are not eligible for the Sickness Disability Rider.</p> <p>11. What is your height and weight?</p> <p>Height _____ Weight _____</p> <p>12. Have you ever been treated for or diagnosed by a physician as having any of the following conditions or procedures?</p> <table border="0"> <tr> <td>Alzheimer’s Disease</td> <td>Cardiomyopathy</td> </tr> <tr> <td>Chronic Hepatitis</td> <td>Chronic Liver Disease</td> </tr> <tr> <td>Crohn’s Disease</td> <td>Cystic Fibrosis</td> </tr> <tr> <td>Dementia</td> <td>Emphysema</td> </tr> <tr> <td>Heart Valve Replacement</td> <td>Insulin Dependent Diabetes</td> </tr> <tr> <td>Diabetes Diagnosed Prior to age 40</td> <td>Multiple Sclerosis</td> </tr> <tr> <td>Muscular Dystrophy</td> <td>Parkinson’s Disease</td> </tr> <tr> <td>Pulmonary Fibrosis</td> <td>Pulmonary Hypertension</td> </tr> <tr> <td>Regional Enteritis/Ileitis</td> <td>Renal Hypertension</td> </tr> <tr> <td>Rheumatic Fever</td> <td>Schizophrenia</td> </tr> <tr> <td>Systemic Lupus</td> <td>Ulcerative Colitis</td> </tr> <tr> <td>Ulcerative Proctitis</td> <td>Peripheral Vascular Disease (PVD)</td> </tr> <tr> <td>Venous Insufficiency</td> <td></td> </tr> <tr> <td>Chronic Obstructive Pulmonary Disease (COPD)</td> <td></td> </tr> <tr> <td>Stroke or Transient Ischemic Attack TIA (mini-stroke)</td> <td></td> </tr> </table> <p>13. 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)?</p> <p>14. In the past 5 years, did you seek medical advice about any symptom, illness or medical condition that has not yet been diagnosed by a medical professional?</p> <p>15. In the past 5 years, have you had any medical condition(s) for which any medical or surgical procedure(s) (excluding cosmetic procedures) have been discussed, recommended, or planned with a medical professional, and are not yet completed?</p> <p>16. In the past 5 years, have you been treated for or diagnosed by a physician or had surgery for any of the following conditions or procedures:</p> <table border="0"> <tr> <td>Angina and/or Chest Pain</td> <td>Atrial Fibrillation</td> </tr> <tr> <td>Bypass/Stents/Angioplasty</td> <td>Cancer</td> </tr> <tr> <td>Congestive Heart Failure</td> <td>Coronary Artery Disease (CAD)</td> </tr> <tr> <td>Diverticulitis</td> <td>Drug or Alcohol Abuse</td> </tr> <tr> <td>Heart Disease or Disorder</td> <td>Heart Attack</td> </tr> <tr> <td>Nephropathy</td> <td>Sarcoidosis</td> </tr> <tr> <td>Implant of Pacemaker/Defibrillator</td> <td></td> </tr> <tr> <td>Heart Surgery (including valve replacement or correction)</td> <td></td> </tr> <tr> <td>Kidney Disease or Disorder (not including stones)</td> <td></td> </tr> <tr> <td>Liver Disease or Disorder (excluding Hepatitis A)</td> <td></td> </tr> </table> <p>17. In the past 12 months, have you received medical treatment either as an inpatient or outpatient in a hospital, an emergency room, an observation room, or an ambulatory surgical center for a period of more than 24 hours for any reason other than normal childbirth?</p>	Alzheimer’s Disease	Cardiomyopathy	Chronic Hepatitis	Chronic Liver Disease	Crohn’s Disease	Cystic Fibrosis	Dementia	Emphysema	Heart Valve Replacement	Insulin Dependent Diabetes	Diabetes Diagnosed Prior to age 40	Multiple Sclerosis	Muscular Dystrophy	Parkinson’s Disease	Pulmonary Fibrosis	Pulmonary Hypertension	Regional Enteritis/Ileitis	Renal Hypertension	Rheumatic Fever	Schizophrenia	Systemic Lupus	Ulcerative Colitis	Ulcerative Proctitis	Peripheral Vascular Disease (PVD)	Venous Insufficiency		Chronic Obstructive Pulmonary Disease (COPD)		Stroke or Transient Ischemic Attack TIA (mini-stroke)		Angina and/or Chest Pain	Atrial Fibrillation	Bypass/Stents/Angioplasty	Cancer	Congestive Heart Failure	Coronary Artery Disease (CAD)	Diverticulitis	Drug or Alcohol Abuse	Heart Disease or Disorder	Heart Attack	Nephropathy	Sarcoidosis	Implant of Pacemaker/Defibrillator		Heart Surgery (including valve replacement or correction)		Kidney Disease or Disorder (not including stones)		Liver Disease or Disorder (excluding Hepatitis A)		<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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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 & Gender	Date of Birth and State (mm/dd/yyyy)
	<input type="checkbox"/> Male <input type="checkbox"/> Female	
	<input type="checkbox"/> Male <input type="checkbox"/> Female	
	<input type="checkbox"/> Male <input type="checkbox"/> Female	
	<input type="checkbox"/> Male <input type="checkbox"/> Female	
	<input type="checkbox"/> Male <input type="checkbox"/> Female	
	<input type="checkbox"/> Male <input type="checkbox"/> Female	
	<input type="checkbox"/> Male <input type="checkbox"/> Female	
	<input type="checkbox"/> Male <input type="checkbox"/> Female	

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

SECTION VII

Payment Information

Payment Mode:	Premium Total:
Current Direct Bill Options: <input type="checkbox"/> Monthly Bank Draft <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual	Base Coverage \$ _____
Current Payroll Bill Options: <input type="checkbox"/> Payroll deduction <input type="checkbox"/> Federal Allotment Frequency: <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 24 <input type="checkbox"/> 26 <input type="checkbox"/> 52 <input type="checkbox"/> Section 125	Sickness Disability Rider \$ _____
Monthly Bank Draft is the only mode available on the following: <input type="checkbox"/> Credit Union Account Number _____	Public Safety Rider \$ _____
<input type="checkbox"/> Employee Non-payroll Account Number _____	Waiver of Premium Rider \$ _____
	Physician's Office Additional Benefits Rider \$ _____
	Total \$ _____
	Amount Collected \$ _____
	<input type="checkbox"/> Draft initial premium payment (an "Authorization to Draft Initial Premium" form must be completed.)
	<input type="checkbox"/> Check remitted with application
	*All checks should be payable to: Washington National Insurance Company

Special Instructions:

Applicant
signature here ➤

SECTION VIII

Applicant's Statement

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. For ages 65 and above, I acknowledge I have received the booklet containing insurance advice for people eligible for Medicare. I acknowledge that I have received an Outline of Coverage. **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 knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

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

PLEASE REVIEW THIS NOTICE CAREFULLY

IT DESCRIBES OUR INSURANCE INFORMATION PRIVACY PRACTICES AND YOUR PRIVACY RIGHTS AND CHOICES.

IT DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Our Privacy Commitment

This notice describes what we do with your Personally Identifiable Information ("PII") and the choices you have about how it is used and shared.

PII is information that clearly identifies you. Your name, address, policy number, birth date, Social Security number, health and financial information, and other nonpublic information is PII.

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

This notice explains the privacy practices of insurers owned by CNO Financial Group, Inc. ("Affiliates"). This notice covers health insurance, life insurance and annuities issued by Affiliates, as well as third-party insurance products that are administered by CNO Services, LLC.

CNO insurance Affiliates include: Bankers Life and Casualty Company, Bankers Conesco Life Insurance Company [a New York licensed and domiciled insurance company], Colonial Penn Life Insurance Company, Conesco Life Insurance Company of Texas and Washington National Insurance Company. As of July 1, 2014, CNO Services, LLC serves as administrator for Conesco Life Insurance Company, a subsidiary of Wilton Reassurance Company.

We may change our privacy practices at any time. For purposes of federal health privacy law, CNO is an Affiliated Covered Entity. This means our health 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, procedures, and training designed to keep PII safe and secure. We use privacy and security safeguards that obey state and federal regulations. If the laws differ, 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 or ask us to perform a policy transaction. We ask for your name, contact information, birth date, and may need your Social Security number. Depending on the coverage you apply for, we may ask about your past or present health status, financial assets or other identifying information.

We collect PII from third parties if it is required to determine your eligibility for coverage or to process a claim. We may get reports from MIB, Inc., a nonprofit insurance support organization that exchanges information with its members. We obtain your permission before we obtain from or provide information about you to MIB. We may ask about your insurance coverage with other companies, including CNO Affiliates, such as coverage levels or payment history. We ask your permission to obtain this information, unless the law allows otherwise. We are not permitted to use genetic health information to make underwriting decisions except in connection with long term care policies.

Mostly, we use your PII to issue and service your coverage with us, such as to pay claims or to conduct quality assessments and customer service improvement activities, or in connection with risk management and business planning functions. If permitted by law, we may also use your PII to offer you other insurance-related products and services. If you have health coverage, we will not use PII associated with your health plan for marketing purposes unless the law allows it, such as when you discuss your insurance needs directly with your insurance agent.

Sharing PII Fairly and Legally

We may disclose your PII to nonaffiliated companies that perform services for us to administer your policy, or with whom we have joint marketing agreements. We have written agreements with these companies requiring them to maintain strict privacy and security standards. You cannot opt out of this type of sharing.

We may disclose your PII to Affiliates, and other entities with which we are under common control or nonaffiliated companies as allowed by law, to protect the security of our records and information systems, to meet legal or regulatory requests, or to follow state, federal or local laws (such as for public health purposes, to report abuse or neglect, or to comply with a court order). You cannot opt out of this type of sharing.

In addition, we may make limited disclosures of your PII to individuals involved in your care if you are incapacitated, or in an emergency situation if we believe the disclosure would be in your best interest.

Your Opt-Out Rights

If the law allows us to share your PII for marketing purposes, you have the right to opt out by calling the toll-free number listed below. You can restrict sharing of your PII with CNO Affiliates, nonaffiliated companies or both. If you opt out of Affiliate sharing, this choice is effective for five years. If you opt out of nonaffiliated company sharing, this choice 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.

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

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

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

You may also opt out by writing to us. We need your full name, mailing address, and policy number(s).

You Can Access Your PII

You may ask to see or receive a copy of the PII we maintain about you. Please ask us in writing. We will need your full name, mailing address, and policy number(s). We will respond within the time frame required by law, generally about 30 days after receipt. Your request should be signed by you or your legal representative. We may charge a reasonable, cost-based fee.

You Can Correct Your PII

You may ask us to correct the PII we maintain about you. Please ask us in writing. We will need your full name, mailing address, and policy number(s). 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 agree to your request if we did not create the PII, if we do not store the information, or if your PII is already accurate and complete. Your request should be signed by you or your legal representative. If we deny your request, we will explain why in writing and let you know how to submit a complaint to us or regulatory agencies.

You Can Request a List of Disclosures of Your PII

You may ask us for a list of disclosures of your PII made within the last six years for health plans and two years for other types of insurance. Please ask us in writing. We will need your full name, mailing address, policy number(s), and the time period of your request. We do not have to include disclosures that were requested by you (or your legal representative), or disclosures we made about payment or health care operations. Your request should be signed by you or your legal representative. We will provide this information free of charge once a year; otherwise, we may charge a reasonable, cost-based fee.

You Can Request Information on 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 in writing 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 1) your state department of insurance or 2) the Secretary of the U.S. Department of Health and Human Services in Washington, D.C. within 180 days of the conduct. We will not retaliate against you for filing a complaint.

You Can Request Alternative Communications

You may ask us to communicate with you in a different way, such as directing your mail to a post office box. Please ask us in writing. We will consider all reasonable requests, but must say "yes" if you tell us that disclosure of all or part of your PII could place you in danger. Your request for highly confidential handling should be signed by you or your legal representative.

Your Right to Request a Restriction on Communications

You may ask that we not share your PII (including health information) regarding payment or for our business operations with certain persons. Please ask us in writing. We will consider your request, but are not required to agree if we believe it would affect your medical care or performance of our business operations. If we deny a new or ongoing request, we will explain why to you in writing. Your request should be signed by you or your legal representative. You can revoke your request at any time by phone or in writing.

Additional Privacy Standards for Health Insurance Plans

If you have health insurance coverage, there are some additional privacy standards that apply to you. Remember, PII includes specific health and financial information, as well as personal identifiers and demographic information about you.

- You have the right to be notified following a breach of your unsecured PII.
- Except in limited circumstances, we are required to obtain your permission to use or disclose PII for marketing purposes.
- We will not disclose psychotherapy notes, or sell or use PII for fundraising purposes without obtaining prior written permission.
- Except for the disclosures of PII made at your request, or for payment activities or health care operations, we will obtain your permission before using or disclosing your PII.

Information Practices for Determining Eligibility for Insurance

Fair Credit Reporting Act Notice

As part of our life insurance 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 November 1, 2015.



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 other CNO Affiliates 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

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)

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)

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.

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

ACCIDENTAL DEATH AND DISEMEMBERMENT

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

POLICY FORM CIC1022KS

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.

DISEMEMBERMENT: 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: 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, 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: Being exposed to 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.

CANCELLATION OF INSURANCE:

The Policyowner may request cancellation of the Policy at any time. The Policyowner may also cancel any coverage provided to an Insured at any time. The request must be in writing and sent to Us at Our Administrative Office. Cancellation will become effective on the day We receive the request, or on a later date specified in the request. In the event of cancellation, We will promptly return the unearned portion of any premium paid. The unearned premium will be returned based upon the pro-rata computation. Cancellation will not prejudice a claim for Loss incurred prior to cancellation.

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.

Your modal premium for the benefits selected is:

Policy: \$ _____.

Rider(s): \$ _____

Total Premium: \$ _____

AGENT INFORMATION:

Date	Agent Name	Agent Signature

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.

Policy form: CIC1022KS

WASHINGTON NATIONAL INSURANCE COMPANY

Home Office

11825 N. Pennsylvania Street

Carmel, IN 46032

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