



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

**SECTION I**

Is this a reinstatement? Yes  No  Is this an upgrade of existing coverage? Yes  No

Is this a guaranteed conversion? Yes  No

If "Yes" to any of the above, provide existing policy number: \_\_\_\_\_

Requested Effective Date: \_\_\_\_\_

**SECTION II**

|   |                          |       |                        |  |        |
|---|--------------------------|-------|------------------------|--|--------|
| Please Print Primary Applicant's Name (First, Middle Initial, Last)           |                          |       |                        | Height   | Weight |
| (Applicant)<br><input type="checkbox"/> Male <input type="checkbox"/> Female  | Date of Birth (mm/dd/yy) | Age   | Social Security Number | (Area Code) Phone Number                                   |        |
| Spouse's Name(if applying for spouse insurance) (First, Middle Initial, Last) |                          |       |                        | Height   | Weight |
| (Spouse)<br><input type="checkbox"/> Male <input type="checkbox"/> Female     | Date of Birth (mm/dd/yy) | Age   | Social Security Number | If applying for Child(ren) Insurance, complete Section IV. |        |
| Applicant's Street Address  |                          |       |                        |  |        |
| City  |                          | State |                        | Zip Code   |        |
| E-mail Address:   |                          |       |                        |  |        |

**SECTION III If you are applying through a guaranteed conversion, please answer only questions 1 and 2.**

|  |   |
|--|---|
| <b>Please answer the questions below for the type of insurance being applied for:</b>  |   |
| <b>For All Insurance Applied For:</b>  |   |
| 1. Will this insurance replace any accident and sickness insurance currently in force with us or another company for any person to be insured? .....<br>If "Yes," please complete the "Notice to Applicant" form.  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 2. Have you or anyone to be covered used any tobacco products in the past 10 years? .....  | Primary Applicant:<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>Spouse:<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. In the past 10 years, have you or anyone proposed for coverage been treated for or diagnosed by a physician as having Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?.....<br>If "Yes" to question 3, the named individual(s) is not eligible for coverage.<br>Please list individual(s) name: _____<br>_____ | <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| <b>For Cancer Coverage.</b>  |   |
| 4. Do you currently have insurance providing benefits for cancer only? .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 5. Has any person proposed for coverage had within the past 5 years: cancer or any malignancy which includes: carcinoma, sarcoma, Hodgkin's disease, leukemia, lymphoma, malignant tumor, cirrhosis, hepatitis B or C, blood disorder, emphysema, or chronic obstructive pulmonary disease (COPD)?.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 6. Within the last 5 years, has anyone to be covered been treated for or diagnosed as having a pre-leukemic condition, a pre-malignant condition or a condition with malignant potential? .....<br>If "Yes" to question 5 or 6, the named individual(s) is not eligible for coverage. Please list individual(s) name: _____<br>_____   | <input type="checkbox"/> Yes <input type="checkbox"/> No  |

**For Heart Attack, Stroke, End-Stage Renal Failure Coverage.**

7. Has any person proposed for coverage had within the past 5 years:  
heart attack, heart disease, heart surgery, congestive heart failure, angina or prescribed nitroglycerin, any other abnormality of the heart including coronary artery disease, peripheral vascular disease, stroke, transient ischemic attack, or any other cerebrovascular disease, any abnormal kidney function, kidney disease, renal failure or insufficiency, required dialysis, diabetes, spina bifida, lupus, or sickle cell anemia?
8. Has any person proposed for coverage had a blood pressure reading in the last 6 months of greater than 150 systolic or 95 diastolic?.....  
If "Yes" to question 7 or 8, the named individual(s) is not eligible for coverage. Please list individual(s) name: \_\_\_\_\_  
\_\_\_\_\_

Yes  No

Yes  No

**SECTION IV**

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 | Date of Birth |
|------|--|---------------|
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Check here if additional space is needed and attach separate sheet.

**SECTION V**

**Coverage Selection:**

Critical Illness Cancer Only Coverage     Critical Illness without Cancer Coverage     Critical Illness with Cancer Coverage

Coverage Option:  Option A     Option B

Coverage Level:

\$10,000     \$20,000     \$30,000     \$40,000     \$50,000     \$60,000     \$70,000

Optional Rider:

Cash Value \*not available with Section 125

| Payment Mode:  | Premium Total:  |
|--|---|
| <p><b>Current Direct Bill Options:</b></p> <p><input type="checkbox"/> Monthly Bank Draft</p> <p><input type="checkbox"/> Semi-Annual</p> <p><input type="checkbox"/> Annual</p> <p><b>Current Payroll Bill Options:</b></p> <p><input type="checkbox"/> Payroll deduction</p> <p><input type="checkbox"/> Federal Allotment</p> <p><b>Payroll Deduction Frequency:</b></p> <p><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</p> <p><input type="checkbox"/> Section 125</p> <p>Monthly Bank Draft is the only mode available on the following:</p> <p><input type="checkbox"/> Credit Union<br/>Account Number _____</p> <p><input type="checkbox"/> Employee Non-payroll<br/>Account Number _____</p> | <p>Applicant Premium      \$ _____</p> <p>Spouse Premium        \$ _____</p> <p>Child(ren) Premium    \$ _____</p> <p>Optional Rider         \$ _____</p> <p>Total                    \$ _____</p> <p>Amount Collected     \$ _____</p> <p><input type="checkbox"/> Draft initial premium payment (an "Authorization to Draft Initial Premium" form must be completed.)</p> <p><input type="checkbox"/> Check remitted with application</p> <p><b>*All checks should be payable to: Washington National Insurance Company</b></p> |
| Special Instructions:  |   |

**SECTION VI**

**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 have received the booklet containing insurance advice for people eligible for Medicare. Additionally, 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, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud as determined by a court of law.

Date: \_\_\_\_\_ Signature of Applicant: \_\_\_\_\_

Where Signed: \_\_\_\_\_  
(City, State)

**This Section to be Completed by Agent:** I hereby certify that I have explained to the applicant all exceptions and limitations pertaining to the insurance applied for, including any concerning pre-existing conditions. I hereby certify that I have truthfully and accurately recorded in this application the information supplied by the applicant. I further certify that I am a licensed agent in the state where this application is being solicited by me and signed by the applicant.

Date: \_\_\_\_\_ Signature of Agent: \_\_\_\_\_

Agency: \_\_\_\_\_ Agent Number: \_\_\_\_\_

Agent's E-mail address: \_\_\_\_\_

Agent's Phone Number: \_\_\_\_\_

Mail to Policyholder

Mail to Agent