



INDIVIDUAL

LIFESECURE INSURANCE COMPANY

Hospital Indemnity 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:

- Other Notices to 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, [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:

Michigan

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)

\$ _____

Maximum
Number of Days
per Period of
Confinement:

Select the number of days

3 6 10 21

Note: If you are applying for coverage with dependents, the Hospital Confinement Daily Benefit Amount and Maximum Number of Days per Confinement applies to each covered family member individually.

Optional Benefit Riders

Emergency Room and Ambulance:

Yes No

Outpatient Major Diagnostic Exam:

Yes No

Rehabilitation or Skilled Nursing Facility:
(Days 1-20)

Yes* No *If Yes, \$100/day or \$200/day

Rehabilitation or Skilled Nursing Facility:
(Days 21-100)

Yes* No *If Yes, \$100/day or \$200/day

Lump Sum Hospital Admission:

Yes* No *If Yes, \$500 or \$1,000

Outpatient Surgery:

Yes* No *If Yes, \$500 or \$1,000

Accidental Injury:

Yes* No *If Yes, enter amount for Annual Benefit Bank,
between \$1,000 and \$5,000 (in \$100 increments)
\$ _____

Annual Benefit Bank

If applying for coverage to include spouse/partner
and/or child(ren), the Annual Benefit Bank is shared
between all covered family members.

Total Benefit Bank

2 times Annual Benefit Bank (lifetime maximum)

The following two riders are *not* included in any Guaranteed Issue offering and require responses to underwriting questions in Section 3A.

Outpatient Rehabilitation Therapy: Yes* No *If Yes, \$50/day or \$100/day for 15 or 30 days

First Cancer Diagnosis Lump Sum: Yes* No *If Yes, enter amount between \$1,000 and \$20,000
(in \$1,000 increments) \$ _____

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

Children	Date of Birth	Gender	Relationship
1. _____ Name (First, MI, Last)	_____ (mm/dd/yyyy)	<input type="checkbox"/> M <input type="checkbox"/> F	_____
2. _____ Name (First, MI, Last)	_____ (mm/dd/yyyy)	<input type="checkbox"/> M <input type="checkbox"/> F	_____
3. _____ Name (First, MI, Last)	_____ (mm/dd/yyyy)	<input type="checkbox"/> M <input type="checkbox"/> F	_____
4. _____ Name (First, MI, Last)	_____ (mm/dd/yyyy)	<input type="checkbox"/> M <input type="checkbox"/> F	_____
5. _____ Name (First, MI, Last)	_____ (mm/dd/yyyy)	<input type="checkbox"/> M <input type="checkbox"/> F	_____

If you are age 64.5 through 70 on the date of this application, the applicant(s) in that age range may skip Section 3 and continue with Section 4. However, if you are interested in purchasing the Outpatient Rehabilitation Therapy Rider or First Cancer Diagnosis Lump Sum Rider, please continue to Section 3A.

Section 3 | Medical Information |

Applicant: Height: ____ ft. ____ in. Weight ____ lbs.

Spouse/Domestic Partner: (if applying): Height: ____ ft. ____ in. Weight ____ lbs.

	Self	Spouse/ Partner	Child (ren)
1. Has any person applying for coverage been advised in the <i>past 2 years</i> by a licensed health care practitioner to: <ul style="list-style-type: none"> • 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? 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has any person applying for coverage been hospitalized 3 or more times in the <i>past 2 years</i> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Cancer (other than Basal Cell), Leukemia, Hodgkin's Disease, or Lymphoma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Congestive Heart Failure, Heart Surgery or procedure, Coronary Artery Disease, Stroke (CVA), or Transient Ischemic Attack (TIA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Emphysema, Chronic Obstructive Pulmonary Disease (COPD) or the use of oxygen to assist in breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Alzheimer's Disease, Senile Dementia, Amyotrophic Lateral Sclerosis (ALS), Parkinson's Disease, Systemic Lupus Erythematosus, Hemophilia, Epilepsy or Neurological Disorders (other than Attention Deficit Hyperactivity Disorder, benign essential tremor and migraine disorder)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Having or testing positive for Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Multiple Sclerosis, Muscular Dystrophy, Cerebral Palsy, or Cystic Fibrosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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/Partner**", 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 "**Child(ren)**" 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 "**Child(ren)**" 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 3A | Medical Information |

If you are interested in purchasing the Outpatient Rehabilitation Therapy Rider, please answer the following questions.

- | | Self | Spouse/
Partner | Child
(ren) |
|--|---|---|---|
| 1. Has any person applying for coverage been advised in the <i>past 2 years</i> by a licensed health care practitioner to:
○ have surgery or therapy 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? | <input type="checkbox"/> Yes
<input type="checkbox"/> No | <input type="checkbox"/> Yes
<input type="checkbox"/> No | <input type="checkbox"/> Yes
<input type="checkbox"/> No |
| 2. Has any person applying for coverage received physical / occupational / speech therapy, chiropractic treatment or acupuncture in the last 2 years? | <input type="checkbox"/> Yes
<input type="checkbox"/> No | <input type="checkbox"/> Yes
<input type="checkbox"/> No | <input type="checkbox"/> Yes
<input type="checkbox"/> No |

If you, your Spouse/Partner or Child(ren) answered “Yes” to any part of any question, we regret we cannot offer this Outpatient Rehabilitation Therapy Rider to you, your Spouse/Partner or Child(ren) at this time.

If you are interested in purchasing the First Cancer Diagnosis Lump Sum Rider, please answer the following questions.

- | | Self | Spouse/
Partner | Child
(ren) |
|--|---|---|---|
| 1. Has any person applying for coverage been advised in the <i>past 2 years</i> by a licensed health care practitioner:
○ to have Cancer-related inpatient hospital stay which has not yet been completed, or
○ to have Cancer-related diagnostic tests, surgery, biopsies, staging surgery, or other tests or surgery which have not yet been completed or for which results have not yet been received, or
○ of abnormal diagnostic test results? | <input type="checkbox"/> Yes
<input type="checkbox"/> No | <input type="checkbox"/> Yes
<input type="checkbox"/> No | <input type="checkbox"/> Yes
<input type="checkbox"/> No |
| 2. In the <i>past 5 years</i> , has any person applying for coverage been diagnosed with, treated for, biopsied, or received medical advice from a licensed health care practitioner for Cancer (other than Basal Cell), Leukemia, Malignant Melanoma, Myeloma, Sarcoma, Hodgkins Disease or Lymphoma or pre-malignant or pre-leukemia condition or internal cancer? | <input type="checkbox"/> Yes
<input type="checkbox"/> No | <input type="checkbox"/> Yes
<input type="checkbox"/> No | <input type="checkbox"/> Yes
<input type="checkbox"/> No |

If you, your Spouse/Partner or Child(ren) answered “Yes” to any part of any question, we regret we cannot offer this First Cancer Diagnosis Lump Sum Rider to you, your Spouse/Partner or Child(ren) at this time.

If you are interested in purchasing the Accidental Injury Rider, please complete the Beneficiary Information below.

| Beneficiary Information |

<input type="checkbox"/> Primary	Benefit %	Name
<input type="checkbox"/> Contingent	_____	_____
		(First) _____ (MI) _____ (Last) _____
		Street Address _____ Apt. # _____
		City _____ State _____ Zip Code _____
		Relationship to Primary Applicant: _____

<input type="checkbox"/> Primary	Benefit %	Name
<input type="checkbox"/> Contingent	_____	_____
		(First) _____ (MI) _____ (Last) _____
		Street Address _____ Apt. # _____
		City _____ State _____ Zip Code _____
		Relationship to Primary Applicant: _____

Section 4 | Existing Coverage and Replacement Question |

Will this policy replace any hospital indemnity or health insurance presently in force or previously in force within the last 12 months with:

LifeSecure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any other company?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If Yes, provide details:

Company Name: _____

-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 \$ _____

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

Payment Card #: _____ Expiration Date: _____

Name as it appears on Card: _____

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

Your Payment card information is being used by LifeSecure for the payment of premium for your insurance policy(ies).

For Security purposes, LifeSecure is substituting sensitive payment card data with non-sensitive information (a token). This token is retained and used for processing the payment of your insurance premium. You will be notified in the event of a change to this token consent agreement.

This token consent agreement will remain in place as directed by you. You can cancel this agreement and change to a different premium payment method at any time.

I have reviewed and consent to the use and retention of my token information.

X _____
Cardholder Signature Date

Section 6 | Applicant Acknowledgements and Signatures |

Acknowledgements

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. 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 received the following:

- Notices to the Applicant regarding the Fraud Warning
- Insurance Information Practices
- The Outline of Coverage; and
- The Medicare handbook published by the Centers for Medicare & Medicaid Services (if eligible for Medicare)
- Notice to Applicant Regarding Replacement of Individual Accident and Sickness (if replacing coverage).

Authorizations

I hereby authorize any 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, any prescription data base service, insurance company, consumer reporting agency, administrative services provider or insurance support organization that has any records or knowledge of my health, prescription drug or medication history to give to LifeSecure Insurance Company, and representatives performing services for LifeSecure including its employees, third-party administrative services provider, insurance support organizations, or its reinsurer(s) any such information. This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. 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.

Although my signature on this form is voluntary, I understand that it is required to determine qualification and insurability for an insurance policy to be issued by LifeSecure. Without my signature, I understand that my application for insurance cannot be processed. A copy of this authorization shall be as valid as the original. This authorization applies to any minor dependent for whom insurance is requested. 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 300, New Hudson, MI 48165. Any action taken by LifeSecure (or one of its representatives) before receipt of the written notice of revocation will still be valid. By signing, I also acknowledge that if a party or organization receiving any 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 may 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 answer, otherwise modify this application or policy provision or agree to issue a policy.

I ACKNOWLEDGE THAT THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE.

The Policy provides limited benefits. Review Your Policy carefully!

I have read, or have had read to me, this completed Application. I represent that all information supplied on this Application is true and complete to the best of my knowledge and belief. 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 (or any person to be covered) now have or have had in the past 12 months.

Applicant Signature

Primary Applicant

X _____
Primary Applicant's Signature

Date

Primary Applicant's Printed Name

I represent that I have signed the application in:

City

State



| 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.



LifeSecure Insurance Company
A Stock Company
53200 Grand River Ave
New Hudson, MI 48165
1-888-575-8246
www.yourlifefecure.com

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
53200 Grand River Ave
New Hudson, MI 48165

info@YourLifeSecure.com