ACCIDENT EXPENSE INSURANCE

Insured by Loyal American Life Insurance Company

Application Booklet for CONNECTICUT

- APPLICATION
- ELECTRONIC FUNDS TRANSFER AGREEMENT
- HIPAA NOTICE
- REPLACEMENT NOTICE

Together, all the way.®

Cigna®

ACCIDENT EXPENSE INSURANCE

Insured by Loyal American Life Insurance Company
PO Box 559015, Austin, TX 78755-9015 • (866) 459-4272

Primary Applicant's Name_____
PV Case # _____

Connecticut Application for Insurance

Section A. Accident Expense Coverage Options

1. Applying for: ☐ New Coverage ☐ Reinstatement ☐ Change in Benefit Coverage
   ☐ Add Rider(s) to existing policy* ☐ Add Dependent(s) to existing policy*

   *Policyowner's Name _____

2. Requested Effective Date _____

Section B. Applicant(s) applying for coverage: For Accident Expense coverage, the maximum age for Applicants applying for coverage is up to age 74. Children are eligible for coverage up to age 26. The Primary Applicant's and Spouse's parent(s) are eligible to apply for coverage from age 40 to age 74.

Last Name	First Name	M. I.	Age	Date of Birth (MM/DD/YYYY)	Gender	Social Security Number
Primary Applicant					☐ Male ☐ Female	
Spouse/Civil Union Partner					☐ Male ☐ Female	
Child 1					☐ Male ☐ Female	
Child 2					☐ Male ☐ Female	
Child 3					☐ Male ☐ Female	
Child 4					☐ Male ☐ Female	
Parent 1					☐ Male ☐ Female	
Parent 2					☐ Male ☐ Female	

Section C. Primary Applicant's Information

Home Address required:	**Mailing Address** ***(if different from Home Address):***
Street/PO Box	Street/PO Box
City State ZIP Code	City State ZIP Code

Preferred Email Address

Cell Phone ( ) Home Phone ( ) Work Phone ( )

Primary Applicant's marital status: ☐ Married ☐ Single

If Primary Applicant is a Minor, the Parent or Guardian must complete the following information:

Parent/Guardian's Last Name	Parent/Guardian's First Name	M. I.	Age	Date of Birth (MM/DD/YYYY)	Gender	Social Security Number
					☐ Male ☐ Female	

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Section D. Premium Payment Method

Select one of the following:

☐ Electronic Funds Transfer (Bank Draft) *(complete the Electronic Funds Transfer Authorization form)*
Premium Mode: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

☐ Direct Bill
Premium Mode: ☐ Quarterly ☐ Semi-annually ☐ Annually

☐ List Bill
Premium Mode: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually ☐ 26 Pay ☐ 52 Pay

Group Name_____ Group Number _____ Is this a Section 125? ☐ Yes ☐ No

Section E. Benefit Selection

Accident Policy

Enter Benefit Amount $_____ **Base Modal Premium $**_____

Enter Deductible Amount $_____

Optional Rider Selection *(for additional premium)*

☐ **Parent Rider** *(issue ages 40-74)* **Rider Modal Premium $**_____
(if applying, the Parent Rider benefit amount is equal to the Accident Only Policy benefit amount selected above)

☐ **Declining Deductible Rider** *(not available with Child Only Policies)* **Rider Modal Premium $**_____
(only available with selected Accident Deductible Amounts between $100 and $1,000)

☐ **Vehicular Accidental Injury Cash Benefit Rider** *(issue ages 25-64)* **Rider Modal Premium $**_____
(not available to individuals covered under the Parent Rider)
Enter Benefit Amount $_____

Total Optional Rider(s) Modal Premium $_____

☐ Sold with a new or existing Qualifying Individual Product

☐ Draft Bank Account for First Premium ☐ Check Enclosed *(make checks Payable to **Loyal American Life Insurance Company**)*

Total Base and Optional Rider(s) Modal Premium $_____

Section F. Prior or Other Coverage

	YES	NO
1. Is the Insurance applied for here intended to replace any existing or pending accident or sickness insurance? ... If YES, please provide the following (and complete the Replacement Form): **Note: An Accident Expense policy is not an appropriate replacement for other health and sickness policy types.**	☐	☐
Name of Company _____ Policy Number _____		
2. Is any Applicant eligible for Medicare?	☐	☐
3. Is any Applicant currently covered by any Title XIX program (Medicaid or any similar name)? ..... If YES, any person this applies to is not eligible for coverage.	☐	☐

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Insured by Loyal American Life Insurance Company Primary Applicant's Name_____

Section G. Beneficiary Information: Please provide beneficiary information for the Primary Applicant and Spouse/Civil Union Partner, if applicable. The Primary Applicant will automatically be named the beneficiary for Child(ren) named in the Application. The Parent or Guardian will automatically be named the beneficiary if the Primary Applicant is a minor.

Applicant Name	Name of Beneficiary	Date of Birth (MM/DD/YYYY)	Relationship to Applicant	Primary or Contingent	Percentage of Benefit

Section H. Important Coverage Information

Loyal American Life Insurance Company may decline coverage under the Critical Illness Benefit Rider for any of the Applicants identified on this Application based on answers to questions about current or past health status. Loyal will provide coverage to all eligible family members unless otherwise instructed as noted below:

☐ I, the Primary Applicant, instruct that Loyal not provide coverage to any eligible Applicants unless ALL family members are approved for coverage.

OR ☐ I, the Primary Applicant, instruct Loyal to provide coverage for all approved Applicants if an Applicant is declined coverage.

Section I. Policyowner's Statements and Agreements

I hereby apply to Loyal American Life Insurance Company for insurance coverage to be issued based upon the truth and completeness to the best of my knowledge and belief of the answers to the above questions and understand and agree that: (1) no Agent has the authority to waive the answer to any questions on the Application; (2) no insurance will be effective until (a) this signed Application has been accepted upon review of the answers I have provided and any medical information reviewed by Loyal, (b) the initial premium has been paid, and (c) a contract has been issued by Loyal American Life Insurance Company; and (3) I have received the Outline of Coverage for the policy applied for, the Replacement Notice form, if applicable, and, if eligible for Medicare, the required Guide to Health Insurance for People with Medicare.

I understand that 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 and may be subject to civil and criminal penalties.

The Primary Applicant must sign and date, acknowledging their understanding and agreement to the conditions listed herein. The above statements are true and complete. I understand and agree that for all Applicants these statements shall be the basis for determination of acceptance for coverage under my applicable Loyal policy. I acknowledge and agree that any material misrepresentation or material omission of any Applicant may render this contract null and void from its date of issue in accordance with applicable law. If coverage is revoked, I will receive written notice that will explain the decision and my right to appeal. Loyal will return all paid premiums and fees less any claim payments.

As an alternative to court action, any matter in dispute between me and the Company may be subject to voluntary non-binding arbitration governed by the provisions of the Commercial Arbitration Rules of the American Health Lawyers Association. Any decision reached by arbitration shall be binding upon both myself and the Company and may be entered as a judgment in any court of proper jurisdiction. By signing this Application, I acknowledge that I am giving up the right to a trial in court, both with and without a jury.

Any Applicant who is currently covered by Medicaid should not purchase this coverage.

Primary Applicant's Signature or Parent or Guardian if Applicant is a minor (Policyowner)	Today's Date (MM/DD/YYYY)
Spouse's/Civil Union Partner's Signature	Today's Date (MM/DD/YYYY)

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Section J. Agent(s) Certification

Agent shall list any health insurance policies they have sold to the Primary Applicant.

1. List policies sold which are still in force (if this does not apply, state "None") _____
   _____
2. List policies sold in the past five (5) years which are no longer in force (if this does not apply, state "None") _____
   _____

	YES	NO
3. Have you submitted any Applications or have knowledge of any Applications submitted for the Primary Applicant that have been declined? ..... If YES, please explain _____ _____	☐	☐
4. Have you reviewed the Application for correctness and omissions?	☐	☐
5. Was the Application completed by you in the Primary Applicant's physical presence?	☐	☐
6. Was the Application completed by you over the phone?	☐	☐
7. Do you have knowledge or reason to believe the replacement of existing insurance may be involved?	☐	☐

8. I certify that I have provided the Primary Applicant with the following documents:
   a. Application Packet *(Phone Sales only)* b. Outline of Coverage c. Other _____
   I further certify that I have delivered the documents to the Primary Applicant *(check all that apply; must select at least one)*:
   ☐ In person *Date* _____ ☐ Mail *Date* _____ ☐ Email *Date* _____ ☐ Fax *Date* _____
   ☐ Other *(explain)* _____ *Date* _____

I certify that I have interviewed the Primary Applicant, asked all of the questions as written on the Application, and I have truly and accurately recorded on the Application the information supplied to me by the Primary Applicant.

Printed Name of Licensed Agent	Signature of Licensed Agent	Writing Number	Percentage
Printed Name of 2nd Licensed Agent	Signature of 2nd Licensed Agent	Writing Number	Percentage

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

LOYAL AMERICAN LIFE INSURANCE COMPANY® • PO BOX 559015 • AUSTIN, TX 78755-9015

Proposed Insured's Name		**Policy Number (if available)**
Financial Institution Name and Telephone Number		
Financial Institution Address		
9-digit Routing Number	**Account Number**	**Requested Withdrawal Date (1st - 28th)**

Withdraw Payment: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Type of Account: ☐ Personal Checking Account ☐ Personal Savings Account ☐ Corporate/Business Checking

Name of Employer Group _____

Purpose for submitting this Authorization (check appropriate box(es)):

☐ New authorization ☐ Change in checking/savings account

☐ Change in financial institution ☐ Change in existing coverage

For Checking Account: Please tape a VOIDED check in this box.

For Savings Account: Please attach a letter from the bank stating the account and routing number of your savings account.

APPLICANT INFORMATION FOR FINANCIAL INSTITUTIONS: As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to Loyal American Life Insurance Company provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. I also authorize Loyal American Life Insurance Company and any financial institution it uses to initiate credit entries to my account or to provide refund of premium or association fees (if applicable). I authorize you to accept and to credit these entries to my account. In the event Loyal American Life Insurance Company mistakenly deposits funds into my account, I authorize Loyal American Life Insurance to debit my account for an amount not to exceed the original amount of credit. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

APPLICANT INFORMATION FOR LOYAL AMERICAN LIFE INSURANCE COMPANY: It is understood that the drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract and association fees (if applicable), and no other notice of premiums or association fees (if applicable) due will be given. No premium or association fee (if applicable) shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium or association fee (if applicable) payment has been received by Loyal American Life Insurance Company. The cancelled draft will constitute receipt of premium or association fee (if applicable) payment. The privilege of paying premiums and association fees (if applicable) under this Plan may be revoked by Loyal American Life Insurance Company if any draft is not paid upon presentation. The payment of premiums and association fees (if applicable) under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by Loyal American Life Insurance Company upon 30 days written notice.

Name of Payor (if other than Insured) **Payor's Address**

Print name of Depositor (as it appears on account) **Signature of Depositor** **Date**

AUTHORIZATION FORM FOR DISCLOSURE OF AN APPLICANT'S PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of protected health information about me as described below.

1. The Company, as used in this authorization, shall mean American Retirement Life Insurance Company®; or Central Reserve Life Insurance Company; or Loyal American Life Insurance Company®; or Provident American Life & Health Insurance Company.
2. I authorize any licensed physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager, or other medical or medically-related facility, the U. S. Veterans Administration and Selective Service System, insurance company, MIB, Inc., or any other organization, institution, or person that has any records or information available as to the diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment relating to me or my family to disclose to the Company's underwriting, new business, claims, sales agents, and premium accounting representatives any such records or information.
3. The protected health information described above will be disclosed to the Company to determine my or my family's eligibility to obtain coverage under the policy for which I/we have applied, and to determine the rates and terms which apply to the policy.
4. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Privacy Office at PO Box 26580, Austin, Texas 78755-0580.
5. I understand that the information which will be provided under this authorization is necessary for the Company to determine my eligibility for coverage under the policy and that the Company will condition its approval and issuance of the policy on my providing this authorization, and my application may be denied if I refuse to provide this authorization.
6. I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
7. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this authorization upon request. This authorization will expire twenty-four (24) months from the date it is signed.
8. If you are the representative of an Applicant, describe the scope of your authority to act on the Applicant's behalf:

_____

Applicant's Name

Name of Applicant's Personal Representative, if applicable

Applicant's Social Security Number

Relationship of Personal Representative to the Applicant

Signature of Applicant **Date**

Signature of Personal Representative **Date**

Signature of Company's Agent **Date**

A signed copy of this form will be provided with the policy if issued and any other time upon request.

Loyal American Life Insurance Company®
PO Box 559015, Austin, TX 78755-9015 • Toll Free: 866-459-4272

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application and information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Loyal American Life Insurance Company®. Your new policy provides 30 days in which you may decide, without cost, whether or not you decide to keep this policy. For your own information and protection, you should be aware of and seriously consider certain factors which 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 under the new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, 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 any 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