

CENTRAL UNITED LIFE INSURANCE COMPANY/FAMILY LIFE INSURANCE COMPANY

[10700 Northwest Freeway, Houston, TX 77092]

Med-Life Circle of Protection - Combination Application

Requested Effective Date: _____

- New Application
- Group No. _____
- Reinstatement
- Benefit Increase

APPLICANT'S INFORMATION				
Name (Last, First, Middle Initial)	Date of Birth	Height (Ft.)	Weight (Lbs.)	Gender (M or F)
Address (Street, City, State, ZIP Code)				
Telephone Numbers (Home, Work and Cell)			Email Address	
Social Security Number	Primary Employer	Type of Business		
Current Occupation – Describe and give exact duties				
Beneficiary Insured/Relation		Contingent Beneficiary/Relation		
Beneficiary Spouse/Relation		Contingent Beneficiary/Relation		

DEPENDENT'S INFORMATION					
Name (Print Full Name)	Social Security Number	Gender (M or F)	Date of Birth	Height	Weight (Lbs.)

COVERAGE APPLIED FOR						
MED-LIFE HEALTH INSURANCE	Plan Type: <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 4	Surgical Benefit Amt: <input type="checkbox"/> 1 Unit <input type="checkbox"/> 2 Units	Coverage Applied For: <input type="checkbox"/> Individual <input type="checkbox"/> Individual/Children <input type="checkbox"/> Individual/Spouse <input type="checkbox"/> Family	Premiums:		
Note: This policy does not provide benefits for Loss or Losses due to Pre-Existing Conditions, as defined in the policy, unless waived by the Company by policy endorsement.						
24-HOUR ACCIDENT EXPENSE POLICY	Benefit Amount: <input type="checkbox"/> 1.0 Units <input type="checkbox"/> 2.0 Units	Coverage Applied For: <input type="checkbox"/> Individual <input type="checkbox"/> Individual/Spouse <input type="checkbox"/> Single Parent <input type="checkbox"/> Family <input type="checkbox"/> Child(ren) Only	Optional Rider: Accident Disability <input type="checkbox"/> Yes <input type="checkbox"/> No Income Benefit: <input type="checkbox"/> 12 Months Occupation: <input type="checkbox"/> Type 1 Benefit Amount: <input type="checkbox"/> 1.0 Units	Duration _____ <input type="checkbox"/> 24 Months <input type="checkbox"/> Type 2 <input type="checkbox"/> 2.0 Units	Premiums:	
CRITICAL ILLNESS/CPR	<input type="checkbox"/> Without Cancer <input type="checkbox"/> With Cancer	Coverage Applied For: <input type="checkbox"/> Individual <input type="checkbox"/> One Parent <input type="checkbox"/> Two Parent	Plan: <input type="checkbox"/> [\$5,000] <input type="checkbox"/> [\$7,500] <input type="checkbox"/> [\$10,000]	Premiums:		
CRITICAL PROTECTION PLUS	Term: 20 years	<input type="checkbox"/> Plan A – [\$25,000] w/Return of Premium <input type="checkbox"/> Critical Illness Rider: [\$12,500]	<input type="checkbox"/> Plan B – [\$35,000] w/Return of Premium <input type="checkbox"/> Critical Illness Rider: [\$17,500]	<input type="checkbox"/> Plan C – [\$50,000] w/Return of Premium <input type="checkbox"/> Critical Illness Rider: [\$25,000]	Premiums:	

FOR ALL COVERAGES	
1.	Have you or anyone proposed for the coverage been diagnosed or been treated by a member of the medical Profession as having Acquired Immune Deficiency Syndrome (AIDS), "AIDS" related complex (ARC) or "AIDS" related conditions, or tested positive for Human Immunodeficiency virus (HIV) or its antibodies? If "yes" provide details. <input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Do all members to be insured reside in the home of the applicant? If "no" provide details <input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Are all applicants citizens of the U.S.? If "no" provide details. <input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Has any applicant been declined for insurance due to health reasons? If "yes" provide details. <input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Are you or your spouse now pregnant? If "yes" provide details <input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Is any applicant currently taking prescription medication? If "Yes" give their name, name of medication(s) and prescribed dosage <input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Do you have existing life or health coverage? If "Yes" provide face amount of any Life Insurance policies below <input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Is policy intended to replace any other Insurance now in force? If "yes" provide company name, policy number & type of coverage <input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Are you currently employed? If "yes" provide date of employment with your current employer, and number of hours worked per week. <input type="checkbox"/> Yes <input type="checkbox"/> No
Provide additional information requested for questions 1-9 in the space provided below:	

MED-LIFE HEALTH INSURANCE QUESTIONS

1. Has any person proposed for insurance had surgery within the last 5 years? Yes No If yes, provide details (date, reasons, results) _____
2. Has any person had surgery advised but not yet performed? Yes No If yes, provide details. _____
3. Has any person proposed for insurance been treated (including medication), within the last 12 months, by a physician for elevated blood pressure? Yes No If yes, please list the person(s), types of treatment including medication, date last seen by a physician, last blood pressure reading, and how long blood pressure has been under control and date diagnosed. _____
4. Have you or any person proposed for insurance within the past 5 years been diagnosed as having or been told by a doctor that they had any of the following conditions? Yes No If yes, circle the applicable conditions shown below and provide details in the Comment Section below.

a. Addison's Disease	j. Functionally limiting musculoskeletal disease or disorder	t. Mental or Nervous Disorder or disease or disorder of the Central Nervous System
b. AIDS, or tested positive for antibodies to the AIDS virus or HIV virus	k. Grand Mal Epilepsy	u. Multiple Sclerosis
c. Alcoholism & Substance Abuse	l. Heart Attack	v. Paralysis
d. Cataracts uncorrected	m. Hemophilia	w. Ulcerative Colitis
e. Cerebral Palsy	n. Hernia uncorrected	x. Chronic Kidney Disease
f. Cirrhosis of the Liver	o. Hepatitis (other than Virus A)	y. Rheumatoid Arthritis
g. Coronary Bypass	p. Hodgkin's Disease	
h. Currently (or within 3 months) hospitalized or confined to any health care institution	q. Internal Cancer within 5 years	
i. Diabetes (except cases treated by diet alone)	r. Leukemia	
	s. Lung Disorder (Chronic)	

Provide details for any "Yes" answers to question 4:

24 HOUR ACCIDENT EXPENSE POLICY QUESTIONS

1. Has anyone proposed for coverage had a driver's license suspended or revoked within the past 3 years? Yes No
2. Has anyone proposed for coverage had a DWI or DUI within the past 3 years? Yes No
3. Has anyone proposed for coverage a member/participant in a semi-professional or professional sport? Yes No
4. Is anyone proposed for coverage currently under treatment or has any person proposed for coverage been under treatment for drug or alcohol abuse in the past 3 years? Yes No
5. If applying for Non Payroll Coverage: Is any person proposed for coverage blind, bedridden, confined to a wheelchair, unable to walk without a cane or crutch; or in the past five years, has any person proposed for insurance had an Epileptic Seizure, stroke, Parkinson's disease, or Alzheimer's disease? Yes No
6. DI Rider Only: Have you been diagnosed by or received treatment from a member of the medical profession for cancer, heart or vascular disease, chronic obstructive pulmonary disease, renal disease, rheumatoid arthritis, liver disease, sickle cell anemia, asthma requiring steroid therapy, ulcerative colitis, insulin dependent diabetes, Parkinson's disease, seizures, mental and/or nervous disorder, musculoskeletal, knee or back disorder? Yes No

CRITICAL ILLNESS/CPR QUESTIONS

1. Is there any reason you or your spouse are not physically capable of full-time employment? Yes No
2. During the past 10 years, has any person to be insured received medical care for or had:
 - a. any intestinal or urinary tract bleeding, rheumatic fever, heart disease, heart surgery, chest pain, heart attack, stroke, pacemaker implanted, blood vessel surgery or high blood pressure? Yes No
If "Yes" to high blood pressure, give most current blood pressure reading, date, and treatment/medication: _____
 - b. emphysema, chronic bronchitis, tuberculosis, asthma requiring steroid treatment or lung disorders? Yes No
 - c. liver disease, hepatitis, diabetes, multiple sclerosis, or systemic disease such as lupus? Yes No
 - d. mental illness requiring medication or hospitalization, suicide attempted, more than two fainting episodes, medical treatment for alcoholism or drug abuse? Yes No
 - e. kidney failure, internal cancer, malignant melanoma, leukemia, lymphoma or any malignancy prior to this date? Yes No
 - f. hospitalization, or been advised to have any diagnostic tests or surgery? Yes No
 - g. any abnormal blood study results, including high cholesterol, triglycerides or liver enzymes? Yes No
3. Has any parent of any person to be insured at age 50 or less died of colorectal, breast or other internal cancers, diabetes, polycystic kidney disease, heart attack, or stroke? Yes No

CRITICAL PROTECTION PLUS QUESTIONS

1. Has any proposed insured used tobacco in any form within the past 12 months? Yes No
2. In the past seven (7) years, has any person to be insured been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, liver or kidney disease, organ transplant, paralysis, loss of 2 or more limbs, blindness, AIDS, ARC, or immune deficiency, mental illness requiring medication, treatment for alcoholism or drug abuse or has been hospitalized or advised to have any diagnostic tests or surgery for any condition? Yes No
3. In the past seven (7) years have any of the proposed insured's used narcotics, cocaine, hallucinogens, barbiturates, heroin, marijuana or any other drugs not prescribed by a physician? Yes No

Provide salary information for all individuals proposed for coverage:

INSURED'S AUTHORIZATION AND SIGNATURE

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, MIB, Inc., Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or other organization, institution or person, that has any records or knowledge of me or my health or having any non-medical information concerning me to give Central United Life Insurance Company (CUL)/Family Life Insurance Company (FLIC), or its reinsurers, any such information. All information used or disclosed pursuant to authorization may be subject to redisclosure by the recipient and may no longer be protected.

I understand that I am authorizing CUL/FLIC to receive my health information, prescription drug usage history and my non-medical information. I understand that prescription drug usage may be used to verify the presence of certain medical conditions and that such history will not be used to decline coverage. These medical conditions will be confirmed by a telephone interview prior to being used in the underwriting process. The released information received by CUL/FLIC will remain protected by federal and/or state regulations.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with CUL/FLIC.

I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to CUL/FLIC will result in the rejection of the Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying CUL/FLIC in writing at their Administrative Office: [10700 Northwest Freeway, Houston, Texas 77092]. I understand that such revocation will not have any effect on actions CUL/FLIC took prior to their receiving the revocation notice.

I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under a policy. A photocopy of this authorization will be treated in the same manner as the original.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by the Company, the full first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing.

I, the undersigned applicant, certify that I have read, or had read to me, the completed application and that I realize that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part.

WARNING: 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.

NOTICE: ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO CUL/FLIC. DO NOT MAKE THE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

THE EFFECTIVE DATE OF THE POLICY WILL BE THE DATE RECORDED BY THE HOME OFFICE. IT IS NOT THE DATE THIS APPLICATION IS SIGNED. THE POLICY WILL BECOME EFFECTIVE WHEN ALL UNDERWRITING REQUIREMENTS HAVE BEEN SATISFIED AND PREMIUMS PAID.

(Signature of Proposed Insured)

(Signature of Applicant, if other than Proposed Insured)

Signed At (City/State)

Dated (Day/Month/Year)



