PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®

P.O. BOX 4884, HOUSTON, TX. 77210-4884

APPLICATION FOR INSURANCE

INDEMNITY BENEFIT POLICY (Form H-0224.FL)

Calendar Year Maximum Benefit ○ $250,000 ○ $500,000 ○ $1,000,000

Number of Units Per Policy ○ 1 Unit ○ 2 Units ○ 3 Units

Calendar Year Confinement Deductible
○ $100 ○ $500 ○ $1,000 ○ $2,500 ○ $5,000 ○ $7,500 ○ $10,000

Tobacco User-Applicant ○ Yes ○ No Tobacco User-Spouse ○ Yes ○ No

○ New Business
○ Additional Dependent(s)
○ Reinstatement

Requested Effective Date _____

Payment Mode ○ Monthly ○ Quarterly
○ Semi-Annual ○ Annual

Payment Type ○ Monthly Bank Draft ○ Credit Card
○ Direct Bill ○ List Bill

CRITICAL ILLNESS RIDER (Form H-0224.CI.FL) ○ Yes ○ No

If Yes, Plan Type: ○ Insured Only ○ Insured Spouse
○ Dependent Children – how many? _____

Benefit Amount: Insured Only _____ Insured Spouse _____
Dependent Children _____

PRINT APPLICANT'S NAMES (LAST, FIRST, MI, MAIDEN)	SOCIAL SECURITY	SEX	RELATION APPL.	DATE OF BIRTH	AGE	BIRTH STATE	HEIGHT	WEIGHT	PREMIUM
1.									
2.			SPOUSE						
3.			DEP. 1						
4.			DEP. 2						
5.			DEP. 3						
6.			DEP. 4						
7.			DEP. 5						
8.			DEP. 6						

APPLICANT'S ADDRESS (Actual Address. We cannot use a P.O. Box)	CITY	STATE	ZIP	COUNTY
PREMIUM PAYOR ADDRESS (If different than Applicant's Address)	CITY	STATE	ZIP	COUNTY
BUSINESS NAME AND ADDRESS	CITY	STATE	ZIP	
HOME PHONE	BUSINESS PHONE			

DESCRIBE THE OCCUPATION AND SPECIFIC DUTIES FOR EACH ADULT APPLICANT:

APPLICANT: _____

SPOUSE: _____

INDEMNITY BENEFIT POLICY PREMIUM	$_____
CRITICAL ILLNESS RIDER PREMIUM.....	$_____
APPLICATION FEE (non-refundable)	$_____
TOTAL PAYMENT DUE	$_____

STATEMENT OF ELIGIBILITY

IF THE ANSWER TO QUESTION 1-7 IS "YES" THEN THAT APPLICANT IS NOT ELIGIBLE FOR COVERAGE.

	APPLICANT YES/NO	SPOUSE YES/NO	CHILD 1 YES/NO	CHILD 2 YES/NO	CHILD 3 YES/NO	CHILD 4 YES/NO	CHILD 5 YES/NO	CHILD 6 YES/NO
1. Within the past 10 years, has any applicant been diagnosed with or received treatment by a physician, tested positive or taken medication for any of the following conditions? Liver cirrhosis, Hepatitis B, insulin-diabetes and/or neuropathy, ulcerative colitis or Crohn's, Down's syndrome, intellectual disability, Autism, Rheumatoid Arthritis, ALS (Lou Gehrig's Disease), Alzheimer's, Parkinson's, Dementia, cystic fibrosis, heart attack, coronary bypass, coronary artery disease, cerebral palsy, sickle cell or aplastic anemia, leukemia, transplant recipient, multiple sclerosis, muscular dystrophy, lupus, COPD, suicide attempt, Stroke or TIA, paraplegia or quadriplegia, kidney or renal failure, or been hospitalized more than 3 times in the past year?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
2. In the past 10 years, has any applicant tested positive or been diagnosed with or treated by a physician for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
3. Is the primary applicant or any of the applicant's dependent's (spouse, child(ren) under age 25), whether applying for coverage or not, currently pregnant or have a pending adoption?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
4. Within the past 5 years has any applicant been diagnosed with, taken medication or been treated by a physician for internal cancer, malignant melanoma or any other malignancy or been advised to have any diagnostic tests relating to cancer which have not been completed or for which results have not been received?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
5. Within the past 4 years has any applicant used drugs, been diagnosed with or received any medical treatment, taken medication for or been advised to have a medical test for alcohol or drug abuse?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
6. In the past 6 months, has any applicant been confined to a nursing facility (except for short term rehabilitation), bedridden, or been told they are disabled?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
7. Does any proposed insured intend to reside outside the US?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
THE FOLLOWING QUESTIONS APPLY TO THOSE FAMILY MEMBERS THAT ARE ABLE TO QUALIFY FOR COVERAGE BASED ON THE ANSWERS ABOVE, OTHERWISE DO NOT CONTINUE.								
8. Has anyone to be insured used any form of tobacco (including smokeless) or nicotine (e-cigarettes, cigars, pipe or chewing tobacco) within the past 24 months?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
9. In the last 12 months has any applicant been diagnosed, treated or tested by a physician or taken medication for any of the following conditions and has seen a physician more than twice for any of these conditions? Agent: Please add one (1) point for each condition and underline the condition(s).								
a. kidney stones, kidney/bladder or urinary infections, hepatitis A,	☐	☐	☐	☐	☐	☐	☐	☐
b. asthma or bronchitis, sleep apnea, unoperated hernia, pituitary, thyroid, stomach, disc or back,	☐	☐	☐	☐	☐	☐	☐	☐
c.(TMJ) temporomandibular joint, carpal tunnel syndrome, pelvic inflammatory disease,	☐	☐	☐	☐	☐	☐	☐	☐
d. obsessive-compulsive disorder, psychosis, schizophrenia,	☐	☐	☐	☐	☐	☐	☐	☐
e. migraines, endometriosis, uterine fibroids or uterine cyst.	☐	☐	☐	☐	☐	☐	☐	☐

	APPLICANT YES/NO	SPOUSE YES/NO	CHILD 1 YES/NO	CHILD 2 YES/NO	CHILD 3 YES/NO	CHILD 4 YES/NO	CHILD 5 YES/NO	CHILD 6 YES/NO
10. If any applicant had a cesarean section, more than one miscarriage or seen a physician for infertility treatment and has not had a tubal-ligation or hysterectomy and is still of childbearing age, add two (2) points.	☐	☐	☐	☐	☐	☐	☐	☐
11. In the last 12 months has any applicant been diagnosed, treated or tested by a physician or taken medication for any of the following conditions? Agent: Please add two (2) points for each condition(s) and underline the condition(s).								
a. Emphysema and not smoking, non-insulin Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
b. Osteoarthritis, bariatric surgery (weight loss)-gastric bypass, stapling, or lap band	☐	☐	☐	☐	☐	☐	☐	☐
c. cataracts or glaucoma, macular degeneration,	☐	☐	☐	☐	☐	☐	☐	☐
d. cardiac ablation, epilepsy-seizures, hip or knee replacement,	☐	☐	☐	☐	☐	☐	☐	☐
e. mitral valve prolapse, tachycardia-bradycardia or arrhythmia,	☐	☐	☐	☐	☐	☐	☐	☐
12. In the last 12 months, other than conditions mentioned above, has any applicant had any medical or surgical advice including treatment, prescriptions, operations or been advised to have medical test(s) (excluding HIV and AIDS) or surgery that has not yet been performed, or is awaiting a medical test (excluding HIV and AIDS)?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
13. Is there any other condition that will require a rate up? Agent: Please put the appropriate amount of point(s) in the box and provide details in the next section.	☐	☐	☐	☐	☐	☐	☐	☐
Add total points:	☐	☐	☐	☐	☐	☐	☐	☐

IF ANY ANSWER TO ANY PART OF QUESTION 9, 10, 11, 12 or 13 IS "YES" FOR ANY APPLICANT, PROVIDE DETAILS BELOW

Applicant #	Nature of Illness or Accident Include Diagnosis, Operations and Medications	Date Started	Date Ended	Surgery Y/N	Hospitalized From / To	Physician's Name, Address and Provide Number

FAMILY DOCTOR OR DOCTOR OF EACH APPLICANT WHO HAS CURRENT AND COMPLETE MEDICAL RECORDS. (Attach extra page if more space is needed)

APPLICANT #1'S DOCTOR NAME:		Phone Number	
ADDRESS	CITY	STATE	ZIP
SPOUSE'S DOCTOR NAME:		Phone Number	
ADDRESS	CITY	STATE	ZIP
CHILDREN'S DOCTOR NAME:		Phone Number	
ADDRESS	CITY	STATE	ZIP

STATEMENT OF OTHER INSURANCE AND BENEFICIARY

	APPLICANT YES/NO	SPOUSE YES/NO	CHILD 1 YES/NO	CHILD 2 YES/NO	CHILD 3 YES/NO	CHILD 4 YES/NO	CHILD 5 YES/NO	CHILD 6 YES/NO
1. Will the insurance applied for replace or change any existing insurance? If YES, give name of Company and type of Insurance: _____	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
2. Is there any other health, accident or disability insurance in force on the proposed insured? If YES, give name of Company and type of insurance: _____	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○

BENEFICIARY

Primary: _____ Relationship: _____

Secondary: _____ Relationship: _____

If Bank Draft Authorization, ATTACH VOIDED CHECK HERE and sign authorization at right.

AUTHORIZATION TO MY BANK

As a convenience to me, I hereby request and authorize you to pay and charge my account, checks drawn on my account by and payable to the order of the Philadelphia American Life Insurance Company, Houston, Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to 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 check. I further agree that if any such checks be dishonored whether 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. A photocopy of my signature should be honored as if it were original.

_____ X_____

Date Signature (as it appears on bank records)

AUTHORIZATION FOR PAYROLL DEDUCTION

Employee_____ I hereby authorize_____

Name Name of Employer

to deduct from my salary and pay to Philadelphia American Life Insurance Company, Houston, Texas, the monthly deposits as set forth below. Beginning with the month of_____, $_____ each month.

_____ _____

Date Signature of Employee

ELECTRONIC CONSENT AUTHORIZATION

I consent to electronic communication with Philadelphia American Life Insurance Company using the email address provided below. I understand that I can withdraw consent or update my email address at any time by contacting the Company. Electronic communication means informational emails, notices and documents regarding your application and insurance coverage. I understand that a failure to receive such communication due to an incorrect email address is no fault of the Company. If the Company has reason to believe that you have not received Company communications, the Company will deliver all future communication by first-class mail.

_____ _____ _____

Email Address Signature Date

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

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

If you intend to lapse or otherwise terminate existing insurance and replace it with a new plan from Philadelphia American Life Insurance Company, you should be aware of and seriously consider certain factors that may affect your coverage under the new plan.

1. Health conditions that you now have may not be immediately or fully covered under the new plan. This could result in a claim for benefits being denied, reduced, or delayed under the new plan, whereas a similar claim might have been payable under your present plan.
2. If after due consideration, you still wish to terminate your present insurance and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information or correct information regarding the tobacco use of any applicant may cause the company to deny a future claim and to void your coverage as though it has never been in force. After you have completed the application and before you sign it, reread it carefully. Be certain that all information has been properly recorded.
3. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of or addition to your present plan. You should be certain that you understand all the relevant factors involved in replacing or adding to your present coverage.
4. Finally, we recommend that you not terminate your present plan until you are certain that your application for the new plan has been accepted by Philadelphia American Life Insurance Company.

APPLICANT'S STATEMENT AND AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I hereby apply to Philadelphia American Life Insurance Company for coverage under a Policy to be issued in reliance upon the written answers to the questions in this Application which I have answered to the best of my knowledge and belief. I understand and agree that (1) the coverage shall not take effect unless the Application has been accepted and approved in writing by the Company and until the Effective Date of my coverage under the Policy and (2) my coverage will not become effective until all necessary underwriting information has been received and reviewed by the Home Office and that the requested Effective Date may be delayed if the Home Office requires additional medical information to process my Application and (3) the agent does not have the authority to waive a complete answer to any question in the Application, pass on insurability, make or alter any part of the contract, or waive any of the Company's other rights or requirements. I understand and agree that the falsity of any answer or statement in this Application may bar the right to recover under the Policy if such answer materially affects the acceptance of the risk or hazard assumed by the Company. The Company may rely upon this Application and all of the information contained herein.

I hereby authorize and request any physician, hospital, dentist, pharmacy, pharmacy benefit manager, individual, employer, insurance company, law enforcement agency or governmental agency to permit bearer or representative of Philadelphia American Life Insurance Company to view, copy, be furnished a copy or be given details of all record information in connection with any past or present illnesses, financial records, employment records and/or police records. This authorization is to include, but is not limited to information pertaining to diagnosis, care or treatment for psychiatric disorder, drug and alcohol abuse, treatment or prescriptions, testing and/or treatment of HIV (AIDS virus) and/or sexually transmitted diseases. Health information obtained will not be re-disclosed without your authorization unless permitted by law, in which case it may not be protected under federal privacy rules. The results of an HIV-related test shall be confidential and we cannot release or disclose this information except in certain circumstances permitted by law. Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, my employer or consumer reporting agency or insurance company who possesses information of care, treatment or advice of me, my family, or our health may furnish such information to Philadelphia American Life Insurance Company or it's representative or it's reinsurers upon presenting this authorization or a photocopy. Philadelphia American Life Insurance Company or its reinsurers may make a brief report available regarding me or my dependents to other companies to whom I have applied or may apply. I understand that I may revoke this authorization at any time by writing to Philadelphia American Life Insurance Company and that I or my representative is entitled to receive a copy of this authorization form upon request. This authorization shall remain in effect for twenty four (24) months from the date this authorization is signed.

I acknowledge receipt of the Outline of Coverage and Disclosure Notice and have read the Notice to Applicant Regarding Replacement of Accident and Sickness Insurance if this is a replacement.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Dated at_____ on_____ 20_____.
City, State & Zip Month & Day

Signature of Applicant:_____ Signature of Spouse:_____

AGENT USE ONLY

1. Will this coverage applied for replace or effect a change of any coverage with this or any other company? Please Explain: ○ YES ○ NO

_____

2. Did you personally meet with each applicant? (If No, explain) ○ YES ○ NO

_____

3. I have truly and accurately recorded the information as herein supplied by the applicant #1 for all family members. ○ YES ○ NO

4. I have left or made available an Outline of Coverage and a Disclosure Notice. ○ YES ○ NO

5. Mail Policy to: ○ AGENT ○ INSURED

AGENT NAME (Please print first and last name)	ADDRESS	CITY	STATE	ZIP
SIGNATURE OF AGENT ×_____	AGENT NUMBER/LICENSE NUMBER	MONTH	DAY	YEAR

SPLIT AGENT LAST NAME	SPLIT AGENT NUMBER/LICENSE NUMBER	SPLIT AGENT %
1.		
2.		
3.		

Agent Notes