

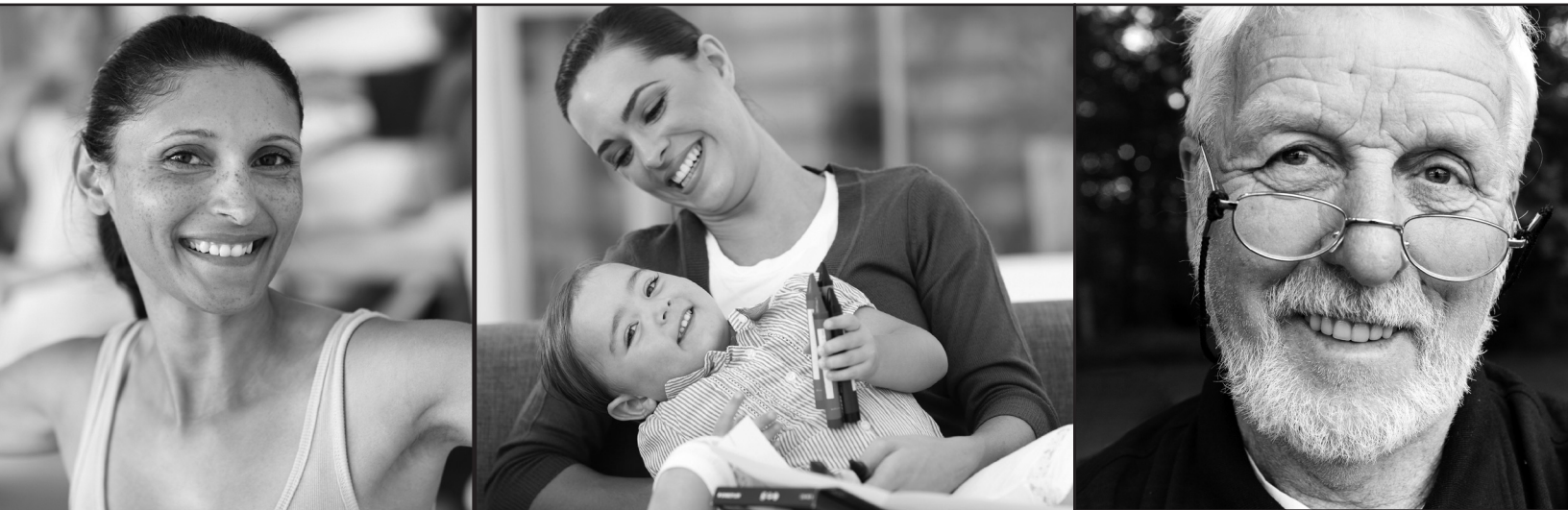
Cigna Supplemental Solutions.
Insured by Loyal American Life Insurance Company

Flexible Choice

CANCER *and*
HEART ATTACK & STROKE

Application Booklet for **NEW JERSEY**

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



Together, all the way.®



LUMP SUM CANCER *and/or* HEART & STROKE INSURANCE POLICIES

Insured by Loyal American Life Insurance Company®
PO Box 5725, Scranton, PA 18505 • (866) 459-4272

Application Policy/Rider Instructions

Please indicate in the benefit selection section of the application where to apply the Hospital Indemnity Rider, Intensive Care Unit Rider, Hospital and Intensive Care Unit Indemnity Rider, and/or Return of Premium Riders.

Example provided below

In this situation, the Hospital and ICU Indemnity rider is to be applied to the Lump Sum Cancer base and the Return of Premium Rider is to be applied to both the Lump Sum Cancer base and the Lump Sum Heart/Stroke base.

Section VII. Benefit Selection

Coverage type:	<input checked="" type="checkbox"/> Individual	<input type="checkbox"/> Individual & Spouse	<input type="checkbox"/> One-Parent Family	<input type="checkbox"/> Family
Policy selection:	<input checked="" type="checkbox"/> Lump Sum Cancer Policy	Benefit Amount \$ <u>5,000</u>	Policy Modal Premium \$ _____	
	<input checked="" type="checkbox"/> Lump Sum Heart/Stroke Policy	Benefit Amount \$ <u>5,000</u>	Policy Modal Premium \$ _____	
Optional Rider selection (for an additional premium):				
<input checked="" type="checkbox"/>	Cancer Recurrence Benefit Rider <i>(can only be sold with Lump Sum Cancer Policy)</i>		Rider Modal Premium \$ _____	
<input checked="" type="checkbox"/>	Heart and Stroke Restoration Benefit Rider <i>(can only be sold with Lump Sum Heart/Stroke Policy)</i>		Rider Modal Premium \$ _____	
<input type="checkbox"/>	Lump Sum Cancer Rider <i>(cannot be sold with the Lump Sum Cancer Policy)</i>	Benefit Amount \$ _____	Rider Modal Premium \$ _____	
<input type="checkbox"/>	Lump Sum Heart/Stroke Rider <i>(cannot be sold with Lump Sum Heart/Stroke Policy)</i>	Benefit Amount \$ _____	Rider Modal Premium \$ _____	
<input type="checkbox"/>	Hospital Indemnity Rider (max issue age 99)	Benefit Amount* \$ _____	Rider Modal Premium \$ _____	
<input type="checkbox"/>	Intensive Care Unit Rider (max issue age 99)	Benefit Amount* \$ _____	Rider Modal Premium \$ _____	
<input checked="" type="checkbox"/>	Hospital and Intensive Care Unit Indemnity Rider (max issue age 99) <i>(cannot be sold with the Hospital Indemnity Rider or the Intensive Care Unit Rider)</i>	Benefit Amount* \$ <u>100</u>	Rider Modal Premium \$ _____	
	APPLY TO CANCER POLICY	*Benefits reduce to 50% of the amount selected at age 65 or older		
<input checked="" type="checkbox"/>	Return of Premium upon Death Rider (max issue age 74) APPLY TO CANCER AND HEART POLICY <i>(Be sure to calculate additional ROP premium for each policy selected.)</i>		Rider Modal Premium \$ _____	
		Total Policy and Optional Riders Modal Premium \$ _____		
<input type="checkbox"/>	Check enclosed (make checks Payable to Loyal American Life Insurance Company)			
<input type="checkbox"/>	Draft bank account for first premium			

If the maximum benefit is paid on the base policy, the policy will not terminate if additional riders are attached under which benefits are still eligible for payment. Lump Sum riders may be converted to a policy, since riders cannot stand alone. The insured must continue paying premium on the base policy for the riders to remain.

If there is no indication on the application as to which base the rider should be applied to, an RFI will be sent out for clarification, which could delay processing.

Note: Not all riders are available in all states. Your actual state application may vary from the sample shown above.

LUMP SUM CANCER *and/or* HEART & STROKE INSURANCE POLICIES

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PO Box 5725, Scranton, PA 18505-5725 • (866) 459-4272

PV Case # _____

Application for Insurance

Section I. 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 II. Applicant(s) applying for coverage

Last Name	First Name	M. I.	Age	Date of Birth (MM/DD/YYYY)	Gender	Social Security Number
Primary Applicant					<input type="checkbox"/> Male <input type="checkbox"/> Female	
Spouse/Civil Union Partner					<input type="checkbox"/> Male <input type="checkbox"/> Female	
Child 1					<input type="checkbox"/> Male <input type="checkbox"/> Female	
Child 2					<input type="checkbox"/> Male <input type="checkbox"/> Female	
Child 3					<input type="checkbox"/> Male <input type="checkbox"/> Female	
Child 4					<input type="checkbox"/> Male <input type="checkbox"/> Female	

Applicant	Spouse/Civil Union Partner
Ht. (ft.-in.) Wt. (lbs.)	Ht. (ft.-in.) Wt. (lbs.)

Section III. Primary Applicant's Information

Home Address Required: Street/PO Box			Mailing Address (if different from Home Address): Street/PO Box		
City	State	Zip Code	City	State	Zip Code
Preferred Email Address					
Cell Phone ()		Home Phone ()		Work Phone ()	

Section IV. 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.

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

Section V. Employment Status

Employer/Job _____ Title/Duties _____
Address _____ Work Location ID (if applicable) _____

Section VI. 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 (payroll deduction)

Premium Mode: Bi-weekly Semi-monthly Monthly Quarterly Semi-annually
 Annually 26 Pay 52 Pay 10thly other_____

Group Name _____ Group Number _____ Is this a Section 125? Yes No

Section VII. Benefit Selection

Coverage type: Individual Individual & Spouse/Civil Union Partner One-Parent Family Family

Policy selection: Lump Sum Cancer Policy **Benefit Amount \$** _____ **Policy Modal Premium \$** _____

Lump Sum Heart/Stroke Policy **Benefit Amount \$** _____ **Policy Modal Premium \$** _____

Optional Rider selection (for an additional premium):

Lump Sum Cancer Rider **Benefit Amount \$** _____ **Rider Modal Premium \$** _____

(cannot be sold with the Lump Sum Cancer Policy)

Lump Sum Heart/Stroke Rider **Benefit Amount \$** _____ **Rider Modal Premium \$** _____

(cannot be sold with Lump Sum Heart/Stroke Policy)

Total Policy and Optional Rider(s) Modal Premium \$ _____

Check enclosed (make checks Payable to **Loyal American Life Insurance Company**)

Draft bank account for first premium

Section VIII. Prior or Other Coverage

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Is the Insurance applied for here intended to replace any existing or pending accident or sickness insurance? | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES, please provide the following (complete the Replacement Notice): | | |
| Name of Company _____ Policy Number _____ | | |
| 2. Is any Applicant eligible for Medicare? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are all Applicants covered by a comprehensive health care policy or comprehensive health maintenance organization (HMO) plan or an employer health benefit plan which provides benefits for hospital and medical services and supplies? ... | <input type="checkbox"/> | <input type="checkbox"/> |
| If NO, the policy cannot be issued. | | |

Section IX. Health History Information

Complete the following:

Parts A & B if applying for Lump Sum Cancer Policy/Rider

Parts A & C if applying for Lump Sum Heart/Stroke Policy/Rider

If the answer is YES to any of the following questions, please explain at the end of Section IX. Attach a separate sheet if needed.

Part A. All Policies and Riders

YES NO

- 1. Has any Applicant been diagnosed with or received medical advice or treatment from a Medical Professional for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) infection? ...

Part B. Lump Sum Cancer Policy/Rider

YES NO

- 2. During the past ten (10) years, has any Applicant consulted with or been diagnosed, treated, hospitalized, or prescribed medication by a Medical Professional for, or had symptoms of, internal cancer, leukemia, Hodgkin's lymphoma (formerly known as Hodgkin's disease), other cancers of the blood, melanoma, malignant tumors, or carcinoma in situ?
- 3. During the past five (5) years, has any Applicant been advised by a Medical Professional to have any diagnostic tests related to cancer that have not been completed, for which test results have not been received, or had abnormal test results where cancer has not been ruled out?

Part C. Lump Sum Heart/Stroke Policy/Rider

YES NO

- 4. During the past ten (10) years, has any Applicant been advised by a Medical Professional to have any diagnostic testing related to any disease of the heart or circulatory system that has not been completed or for which results have not been received? ...
- 5. During the past ten (10) years, has any Applicant consulted with a Medical Professional, or been diagnosed, treated, or hospitalized for myocardial infarction (heart attack), stroke or transient ischemic attack (TIA), any disorder of the heart or of the circulatory system (other than hypertension requiring two (2) or less medications to control), insulin-dependent Diabetes, Diabetic Neuropathy or Retinopathy, uncontrolled hypertension (high blood pressure), or hypertension requiring more than two (2) medications to regulate?

Please record details of all YES answers (any Applicant named will be excluded from coverage, as applicable):

Question #	Applicant Name	Details

Section X. 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 of the answers to the above questions to the best of my knowledge and belief 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.

The Primary Applicant must sign and date, acknowledging their understanding and agreement to the conditions listed herein. The above statements are true and complete to the best of the Applicant's knowledge and belief. 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. 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.

FRAUD WARNING: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

I understand that the Lump Sum Cancer Policy/Rider and Lump Sum Heart/Stroke Policy/Rider will not pay benefits for the first six (6) months after the issue date for any loss caused by a pre-existing condition which I or any Applicant have had in the past six (6) months. PRE-EXISTING condition means a condition Diagnosed or for which medical Advice or Treatment was recommended by or received from a Physician within the six (6) months prior to the issue date.

Primary Applicant's Signature or Parent or Guardian if Applicant is a minor (Policyowner)	Today's Date (MM/DD/YYYY)
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Section XI. 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") _____

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 _____ **YES NO**
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 2 nd Licensed Agent		Writing Number	Percentage

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

LOYAL AMERICAN LIFE INSURANCE COMPANY® • PO BOX 5725 • SCRANTON, PA 18505-5725

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)):

- | | |
|--|---|
| <input type="checkbox"/> New authorization | <input type="checkbox"/> Change in checking/savings account |
| <input type="checkbox"/> Change in financial institution | <input type="checkbox"/> Change in existing coverage |

For checking account:
Refer to the sections on the sample check.

For savings account:
Please verify with your bank the account and routing number of your savings account.

0101

PAY TO THE ORDER OF _____ \$ _____

Dollars

The Routing number is 9 digits between the ■: ■:
■: 123456789 ■:

The Account number is usually to the left of "■". If check number is left of account number, ignore check number.
(34567890 "■"

The Check number should match the upper right corner.
(0101)

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 initial draft will occur when the policy is issued. All subsequent 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 A CONSUMER'S
PROTECTED HEALTH INFORMATION FOR MARKETING PURPOSES
("Authorization")**

1. I hereby authorize the use and disclosure of all my health information, including but not limited to my personal and medical information contained in the Company's records ("Protected Health Information") to American Retirement Life Insurance Company, Loyal American Life Insurance Company®, Cigna Health and Life Insurance Company, Cigna National Health Insurance Company, and their affiliates ("Company") as described below.
2. I authorize the Company to use the Protected Health Information contained in the Company's records, including its underwriting and claim records, to help determine whether I might be interested in or can benefit from other non-health-related insurance products offered by the Company.
3. I understand that the Company will disclose the Protected Health Information to its underwriting staff, new business staff, sales agents, or marketing management for the purpose of marketing non-health-related products to me.
4. I understand that I may revoke this Authorization 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 Steward at PO Box 5700, Scranton, PA 18505-5700.
5. I understand that the Protected Health Information which the Company will use and disclose under this Authorization is not necessary for the Company to determine my eligibility for coverage under the policy and that the Company will not condition its approval and issuance of the policy on my providing 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 redisclosed 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 is 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. This Authorization will remain in effect for two (2) years from the day my policy(ies) is terminated or the day I revoke my permission.
8. By providing my telephone number(s) on the attached application for insurance, I consent to receive calls, texts, or autodialed or prerecorded telemarketing messages from Cigna and its affiliates.

If you are the representative of a Consumer, describe the scope of your authority to act on the Consumer's behalf:

Consumer's Name

Name of Consumer's Personal Representative, if applicable

Signature of Consumer

Date

Relationship of Personal Representative to the Consumer

Signature of Company's Agent

Date

Signature of Personal Representative

Date

A signed copy of this form will be provided to you.

**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 present 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