Cigna Supplemental Solutions®
Insured by Loyal American Life Insurance Company

Flexible Choice

CANCER *and/or* HEART and STROKE INSURANCE

Application Booklet for OHIO

- APPLICATION
- ELECTRONIC FUNDS TRANSFER AGREEMENT
- HIPAA NOTICES
- REPLACEMENT NOTICE
- DISCLOSURE FOR SALE AND SOLICITATION OF MEDICARE SUPPLEMENT, ACCIDENT, AND HEALTH INSURANCE POLICIES

Together, all the way.®

Cigna®

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

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

Phone Verification Case # _____

Application for Insurance
(Issue Ages 18–99)

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 _____

3. Does application pertain to affiliation with or membership in an Association or Group? ☐YES ☐NO

   Association/Group name _____ Assn./Group number _____

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					☐ Male ☐ Female	
Spouse/Domestic Partner					☐ Male ☐ Female	
Child 1					☐ Male ☐ Female	
Child 2					☐ Male ☐ Female	
Child 3					☐ Male ☐ Female	
Child 4					☐ Male ☐ Female	

Section III. Primary Applicant's Information

Home address required:

Street/PO Box

City State ZIP code

Mailing address *(if different from home address):*

Street/PO Box

City State ZIP code

Email address

Cell phone ( ) Home phone ( ) Work phone ( )

Section IV. Beneficiary Information: Please provide beneficiary information for the Primary Applicant and Spouse/Domestic 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 *(answer only if applying for payroll deduction)*

Employer/Job _____ Title/Duties _____

Address _____ Work location ID *(if applicable)* _____

Section VI. Benefit Selection

Coverage type: ☐ Individual ☐ Individual & Spouse/Domestic Partner ☐ One-parent family ☐ Family

POLICY SELECTION – select Policy(ies) and any applicable Riders	Modal premium
☐ **LUMP SUM CANCER POLICY** *($5,000 – $75,000 in $1,000 increments)* Benefit amount $_____	$
☐ **Lump Sum Heart and Stroke Rider** *($5,000 – $75,000 in $1,000 increments)* Benefit amount $_____	$
☐ **Lump Sum Cancer Benefit Builder Rider** ☐ $500 ☐ $1,000	$
☐ **Cancer Recurrence Benefit Rider** *(will match the Lump Sum Cancer Policy benefit amount)*	$
☐ **Radiation and Chemotherapy Benefit Rider** ☐ Prime ☐ Advantage ☐ Supreme *(may only be purchased with the Cancer Recurrence Benefit Rider)*	$
☐ **Specified Disease Benefit Rider** Benefit amount $_____ *(benefit amount must be less than or equal to the Lump Sum Cancer Policy benefit amount and cannot exceed $50,000)*	$
☐ **Accident Fixed Indemnity Benefit Rider** ☐ Prime ☐ Advantage ☐ Supreme	$
☐ **Hospital Indemnity Rider** *($100 – $1,000 in $100 increments)* Benefit amount $_____	$
☐ **Intensive Care Unit Rider** *($100 – $1,000 in $100 increments)* Benefit amount $_____	$
☐ **Hospital and Intensive Care Unit Indemnity Rider** *(cannot be sold with the Hospital Indemnity Rider or the Intensive Care Unit Rider)* *($100 – $1,000 in $100 increments)* Benefit amount $_____	$
☐ **Return of Premium Rider** *(max issue age 74)*	$
☐ **LUMP SUM HEART AND STROKE POLICY** *($5,000 – $75,000 in $1,000 increments)* Benefit amount $_____	$
☐ **Lump Sum Cancer Rider** *($5,000 – $75,000 in $1,000 increments)* Benefit amount $_____	$
☐ **Lump Sum Heart and Stroke Benefit Builder Rider** ☐ $500 ☐ $1,000	$
☐ **Heart and Stroke Restoration Benefit Rider** *(will match the Lump Sum Heart and Stroke Policy benefit amount)*	$
☐ **Specified Disease Benefit Rider** Benefit amount $_____ *(benefit amount must be less than or equal to the Lump Sum Heart/Stroke Policy benefit amount and cannot exceed $50,000)*	$
☐ **Accident Fixed Indemnity Benefit Rider** ☐ Prime ☐ Advantage ☐ Supreme	$
☐ **Hospital Indemnity Rider** *($100 – $1,000 in $100 increments)* Benefit amount $_____	$
☐ **Intensive Care Unit Rider** *($100 – $1,000 in $100 increments)* Benefit amount $_____	$
☐ **Hospital and Intensive Care Unit Indemnity Rider** *(cannot be sold with the Hospital Indemnity Rider or the Intensive Care Unit Rider)* *($100 – $1,000 in $100 increments)* Benefit amount $_____	$
☐ **Return of Premium Rider** *(max issue age 74)*	$
TOTAL PREMIUM	**$**

Section VII. 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 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? If YES, please provide the following (and complete the Replacement Notice):	☐	☐
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.	☐	☐

Section IX. Ineligible Occupations *(answer only if applying for the Accident Fixed Indemnity Benefit Rider)*

Are you currently employed in a non-administrative role in one of the industries listed below or are you an active member of the military?
Primary Applicant: ☐ YES ☐ NO Spouse/Domestic Partner: ☐ YES ☐ NO

- Heavy construction contractors
- Furniture and fixtures
- Fire protection
- Trucking and warehousing
- Primary metal industries
- Lumber and wood products
- Nonmetallic minerals (except fuel)
- Stone, clay, and glass products
- Metal mining
- Bituminous coal and lignite mining

Section X. Health History Information

Complete the following questions. ***If the Primary Applicant answers YES to any Policy question, no one is eligible for coverage.***

If the answer is YES to any of the following questions, please explain at the end of Section X. *Attach a separate sheet if needed.*
If the answer is YES to any question for any Applicant (person(s) to be covered), that person will be excluded from coverage as applicable.

Part A. *Complete for* **all Policies* and Riders** — **YES** **NO**

1. Has any Applicant ever been diagnosed by a medical professional for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for the Human Immunodeficiency Virus (HIV)? ☐ ☐

Part B. *Complete if applying for* **Lump Sum Cancer Policy*/Rider** — **YES** **NO**
Also complete if applying for **Hospital Indemnity Rider, Intensive Care Unit (ICU) Rider, or Hospital and Intensive Care Unit Indemnity Rider**

2. Within the past two (2) years, has any Applicant:
   a. been advised by a medical professional to have any medical test, biopsy, surgery, or other treatment to determine if cancer, carcinoma in situ, or any malignancy is present which has not yet been performed? ☐ ☐
   b. had any tests for which results were abnormal (to include pre-cancerous lesions or cells), inconclusive, not yet known, or where the presence of cancer has not been ruled out? ☐ ☐
3. Within the past five (5) years, has any Applicant been diagnosed with, treated for, or consulted with a medical professional for cancer, carcinoma in situ, malignant melanoma, or any malignancy except basal or squamous cell skin cancer? ☐ ☐

Part C. *Complete if applying for* **Lump Sum Heart and Stroke Policy*/Rider**

4. Primary Applicant: Height *(ft.-in.)* _____ Weight *(lbs.)* _____
   Spouse/Domestic Partner: Height *(ft.-in.)* _____ Weight *(lbs.)* _____

Part D. *Complete if applying for* **Lump Sum Heart and Stroke Policy*/Rider** — **YES** **NO**
Also complete if applying for **Hospital Indemnity Rider, Intensive Care Unit (ICU) Rider, Hospital and Intensive Care Unit Indemnity Rider, or Specified Disease Benefit Rider**

5. Within the past five (5) years, has any Applicant been advised by a medical professional to have any medical or diagnostic testing related to any disease of the heart or circulatory system:
   a. for which results were abnormal or inconclusive? ☐ ☐
   b. that has not been completed or for which results have not been received? ☐ ☐
6. Within the past five (5) years, has any Applicant been diagnosed with, treated for, or consulted with a medical professional for:
   a. a heart attack or any disease or disorder of the heart or vascular system, a stroke or Transient Ischemic Attack (TIA), or high blood pressure requiring three (3) or more medications to control? ☐ ☐
   b. complications of diabetes or insulin-dependent diabetes (excluding gestational), diabetic neuropathy, nephropathy, and retinopathy? ☐ ☐
   c. a disease or disorder of the kidneys (excluding kidney stones) or kidney disease requiring dialysis? ☐ ☐

Part E. *Complete if applying for* **Hospital Indemnity Rider, Intensive Care Unit (ICU) Rider, or Hospital and Intensive Care Unit Indemnity Rider** — **YES** **NO**

7. Is any Applicant currently: ☐ ☐
   a. unable to perform any of his or her activities of daily living (e.g., mobility, transferring, feeding, dressing, toileting) without human supervision or assistance?
   b. undergoing fertility treatments?
8. Within the past twelve (12) months, has any Applicant: ☐ ☐
   a. been hospitalized for an inpatient stay, excluding pregnancy or accidental injury?
   b. missed five (5) or more consecutive days of work due to an injury or sickness (excluding a cold, flu, or pregnancy)?
9. Within the past five (5) years, has any Applicant been diagnosed with, treated for, or consulted with a medical professional for organ transplant or been advised of the need for a transplant? ☐ ☐

Section X. Health History Information (cont'd.)

Part F. *Complete if applying for* **Hospital Indemnity Rider, Intensive Care Unit (ICU) Rider, Hospital and Intensive Care Unit Indemnity Rider, or Specified Disease Benefit Rider** **YES** **NO**

10. Within the past two (2) years, has any Applicant had any tests for which results were abnormal, inconclusive, or not yet known or been advised to have any medical test, surgery, or other treatment which has not yet been performed? ☐ ☐
11. Within the past five (5) years, has any Applicant been diagnosed with, treated for, or consulted with a medical professional for: ☐ ☐
    a. emphysema, Chronic Obstructive Pulmonary Disease (COPD), or any other disease or disorder of the lungs (excluding asthma)?
    b. hepatitis (excluding A), cirrhosis, or any other disease or disorder of the liver?
    c. alcohol or drug abuse or dependency?
    d. any disease or disorder of the nervous system including neuromuscular disease, Multiple Sclerosis (MS), Systemic Lupus Erythematosus (SLE), Parkinson's disease, and Amyotrophic Lateral Sclerosis (ALS)?
    e. aneurysm, blood clot, blood disease or disorder?
    f. pulmonary hypertension, pulmonary fibrosis, tuberculosis, or paralysis?
    g. Alzheimer's disease or dementia?
12. Has any Applicant ever had: ☐ ☐
    a. a defibrillator implanted?
    b. an organ transplant or been advised of the need for a transplant?

Part G. *Complete if applying for* **Specified Disease Benefit Rider** **YES** **NO**

13. During the past five (5) years, has any Applicant had, been diagnosed with, treated for, or taken medication for any of the following: ☐ ☐
    a. aneurysm or pulmonary hypertension?
    b. pulmonary fibrosis or tuberculosis?
    c. paralysis or any disorder of the nervous system including Multiple Sclerosis (MS) or Amyotrophic Lateral Sclerosis (ALS)?
    d. glaucoma, retinitis pigmentosa, macular degeneration, optic neuritis, or blindness lasting more than 30 days?
    e. total loss of speech or permanent and total hearing loss in both ears?
14. Has any Applicant ever had, been diagnosed with, treated for, or taken medication for dementia (including Alzheimer's disease) or any neurological disease or disorder? ☐ ☐

Please record details of all YES answers *(any Applicant named will be excluded from coverage, as applicable)*
if the Primary Applicant answers YES to any Policy question, no one is eligible for coverage

Question #	Applicant Name	Details

Section XI. Policyowner's Statements and Agreements

I hereby apply to Loyal American Life Insurance Company (hereinafter "Company" and "Loyal") for insurance coverage to be issued based upon the truth and completeness 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*.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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 binding arbitration conducted in accordance with the rules of the American Arbitration Association (AAA).

Any Applicant who is currently covered by Medicaid is not eligible for this coverage.

WAITING PERIOD: The Lump Sum Heart and Stroke Policy/Rider, Lump Sum Cancer Benefit Builder Rider, Lump Sum Heart and Stroke Benefit Builder Rider, and Radiation and Chemotherapy Benefit Rider have a 30-day Waiting Period which begins on the issue date. No benefits will be paid for any loss that begins during the Waiting Period. WAITING PERIOD means the first 30 days following an Insured Person's issue date.

I understand that the Lump Sum Cancer Policy/Rider, Lump Sum Heart and Stroke Policy/Rider, Lump Sum Cancer Benefit Builder Rider, Lump Sum Heart and Stroke Benefit Builder Rider, Hospital Indemnity Rider, Intensive Care Unit Rider, Hospital and Intensive Care Unit Indemnity Rider, and Radiation and Chemotherapy Benefit Rider will not pay benefits for the first twelve (12) 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 policy/rider effective date.

I understand that the Specified Disease Benefit Rider will not pay benefits for the first twelve (12) months after the issue date for any loss caused by a pre-existing condition which I or any Applicant have had in the past twelve (12) 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 twelve (12) months prior to the rider effective date.

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

Primary Applicant's signature	Today's date (MM/DD/YYYY)

Section XII. Agent(s) Certification

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 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. ☐ Check box if Agent family business

Printed name of Licensed Agent	Signature of Licensed Agent	Writing number	Percentage
Printed name of 2nd 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 _____

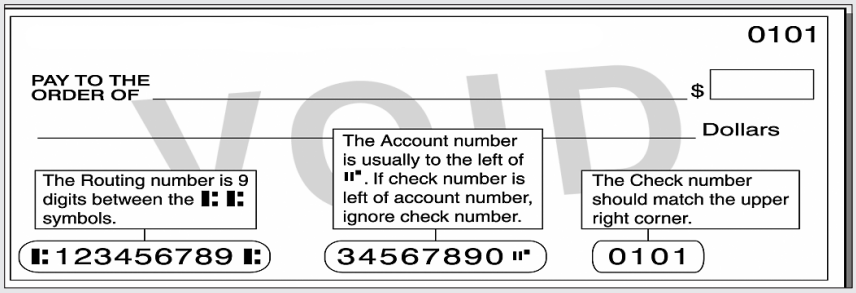
Purpose for submitting this Authorization (check appropriate box(es)):

☐ New authorization ☐ Change in checking/savings account

☐ Change in financial institution ☐ 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.



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 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, Loyal American Life Insurance Company®, Cigna Health and Life Insurance Company, Cigna National Health Insurance Company, and their affiliates as described below.
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. However, MIB, Inc., information will only be shared with the Company's underwriting staff and Medical Director.
3. I authorize the Company to make a brief report of my protected health information to MIB, Inc.
4. 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.
5. 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.
6. 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 5700, Scranton, PA 18505-5700.
7. 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.
8. 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.
9. 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.
10. 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.

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.

Loyal American Life Insurance Company®
PO Box 5725, Scranton, PA 18505-5725 • 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 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

LOYAL AMERICAN LIFE INSURANCE COMPANY®
PO Box 5725, Scranton, PA 18505-5725 • (866) 459-4272

STATE OF OHIO REQUIRED DISCLOSURE FOR SALE AND SOLICITATION OF MEDICARE SUPPLEMENT, ACCIDENT, AND HEALTH INSURANCE POLICIES

The below-named Insurance Agent or Broker certifies:

- that I am licensed as an insurance agent by the state of Ohio;
- that I am appointed to represent Loyal American;
- that I am making the solicitation or sale on behalf of Loyal American;
- that neither myself nor Loyal American has any connection or affiliation with, and are not in any way sponsored by, the federal or state government, the Social Security Administration, the Centers for Medicare and Medicaid Services, or the Department of Health and Human Services.

Agent Name_____ Agent Phone No._____

Address of Agent _____

You, the Applicant, have a right to:

- Verify the information provided above by contacting the Ohio Department of Insurance at:

Ohio Department of Insurance
50 W. Town Street, 3rd Floor, Suite 300
Columbus, OH 43215

- Contact the agent or broker making the solicitation or sale at both an address and telephone number provided above.
- Contact the insurance company or insurance companies on behalf of which the solicitation or sale was made at an address and telephone number provided by the agent or broker.

Payments for insurance premiums should always be made payable to the insurance company.