Continental Life Insurance Company of Brentwood, Tennessee

P.O. Box 14399
Lexington, KY 40512
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Domicile state: Tennessee

Application

Protection Series℠ –

Policy Forms
CLICANFD14
CLICANHS14

Cancer and Heart Attack or Stroke Insurance Plans

Underwritten by

An Aetna Company

Continental Life Insurance Company of Brentwood, Tennessee

Utah

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An Aetna Company

P.O. Box 14399
Lexington, KY 40512

aetna™

Application for Cancer and Heart Attack or Stroke Insurance Plans

from Continental Life Insurance Company of Brentwood, Tennessee

- Print clearly and use blue or black ink.
- Complete all required sections of the application. Any incomplete or missing information could delay processing of your application.

Please select one: ◯ New business
◯ Reinstatement *Policy number* .....
◯ Conversion *Policy number* .....

1. Proposed insured information

If policy is issued, the proposed insured will become the policy owner.

Full name of proposed insured *First, M.I., Last*

Address | Phone

City | State | Zip

E-mail | Social Security Number

Write the birthdate that is on the birth certificate.

Birth date *mm/dd/yyyy* | Age | ◯ Male ◯ Female

Beneficiary name | Relationship

*Domestic partner means your same sex or opposite sex domestic partner or civil union partner as defined by applicable law.

Additional proposed insureds

Family members include spouse or domestic partner* and unmarried child(ren) under age 26.

Full name of spouse *please print*

Sex | Birth date *mm/dd/yyyy* | Age

Full name of child *please print*

Sex | Birth date *mm/dd/yyyy* | Age

Full name of child *please print*

Sex | Birth date *mm/dd/yyyy* | Age

Full name of child *please print*

Sex | Birth date *mm/dd/yyyy* | Age

Full name of child *please print*

Sex | Birth date *mm/dd/yyyy* | Age

If additional space is needed. Please use a separate sheet of paper and attach to the application.

For agent use only:

Mail policy to: ◯ Agent ◯ Applicant

2. Benefits information

Benefits for Cancer and Heart Attack or Stroke are available in $5,000 increments up to $75,000.

Benefits for the Intensive Care Unit Rider are available in $150 increments, up to four increments, for a total benefit of $600 per day.

Example: 2 increments x $150= $300 daily benefit

Premium will be drafted upon policy issue.

Type of coverage selected:
- ◯ Individual
- ◯ Individual and spouse (or domestic partner)
- ◯ Individual and child(ren)
- ◯ Family

Plan selected:	Benefit amount:
◯ Cancer only	$.....
◯ Cancer and heart attack or stroke	$.....
Optional benefit:	**Benefit amount:**
◯ Intensive care unit rider	$.....

Premium mode:
◯ Annual ◯ Semi-annual ◯ Quarterly ◯ Monthly bank draft *(electronic funds transfer or List Bill only)*

Payment method:
◯ Check ◯ Electronic funds transfer ◯ List Bill *Billing file identifier* .....

Premium collected:
$.....

PAYMENT MODES

You have a choice among several payment options or modes for paying your premium (annual, semi-annual, quarterly and monthly bank draft). Each payment mode, other than annual and monthly bank draft, results in higher total yearly premium costs. Reasons for higher costs include added collection and administrative costs, time value of money considerations and lapse rates.

The annual and monthly bank draft modes have the same total yearly premium costs. As a result, there is a time value of money advantage to you for paying monthly versus annually. However, there may be other advantages to you for choosing an annual payment based on your preferences. Your agent can explain the differences in modes and help you decide which is best for you. You have the right to change your payment mode, among the modes available, during the life of your policy.

3. Health questions

COMPLETE THIS SECTION ONLY IF THIS IS AN APPLICATION FOR NEW BUSINESS OR REINSTATEMENT.

Answer all questions.

If any answers to questions in section 3 are "yes", the application will be declined.

A. Within the past 10 years, have you or any person applying for coverage under this policy:

1. Been tested to determine if cancer is present where the results are pending or the test results indicated further treatment or evaluation is needed? ◯ Yes ◯ No
2. Been diagnosed with or treated for or are currently seeking treatment by a medical professional including surgery, radiation or chemotherapy for leukemia, Hodgkin's Disease, lymphoma, melanoma, sarcoma, myeloma, or any internal cancer? ◯ Yes ◯ No
3. Been treated for or been diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for Human Immunodeficiency Virus (HIV)? ◯ Yes ◯ No

⚠ B. Please answer the following questions if you or any person are applying for the First Diagnosis Heart Attack or Stroke or Intensive Care Unit Rider.

Have you or any person applying for coverage:

1. Within the past 6 months, been treated for, or received medical advice for, or taken prescribed medication for uncontrolled high blood pressure? ◯ Yes ◯ No

Health questions *continued*

2. Within the past 10 years, had or been advised to have: any form of heart surgery, or heart related surgery, coronary artery surgery; or angioplasty, pacemaker or defibrillator installed, or arteriogram ? ○ Yes ○ No
3. Within the last 6 months received medical advice or consultation or had medical tests performed (including tests performed during a routine check-up) where the results were other than normal or are still pending? ○ Yes ○ No
4. Within the past 10 years, had symptoms of, ever received medical advice for, or ever taken prescribed medications for any disease (excluding high blood pressure), disorder or abnormality of the heart or circulatory system (which includes arteries, veins, lymphatic nodes and vessels)? ○ Yes ○ No
5. Within the past 10 years, received medical advice for, or taken prescribed medications for myocardial infarction or heart attack, stroke or transient ischemic attack (TIA)? ○ Yes ○ No

C. Please answer the following questions if you are applying for the Intensive Care Unit Rider:

1. Within the past 10 years, have you or any person applying for coverage ever been treated for or received medical advice for diabetes (for which you are being treated with Insulin) or any other disorder, abnormality or condition of the brain, lung, liver or connective tissue? ○ Yes ○ No
2. Are you or any person applying for this Rider currently pregnant? ○ Yes ○ No
3. Are you or any person applying for coverage currently hospitalized, confined in a nursing home, or bedridden? ○ Yes ○ No
4. Within the past 2 years, have you or any person applying for coverage been hospitalized or treated in an emergency room more than 2 times? ○ Yes ○ No
5. Are you or any person applying for coverage currently confined to a wheelchair or need assistance in walking such as with a cane or walker? ○ Yes ○ No

4. Replacement questions

Do you have any other health insurance in force? ○ Yes ○ No

Type of coverage	Policy number	Company
Type of coverage	Policy number	Company

Is the policy being applied for intended to replace any other insurance? ○ Yes ○ No

Type of coverage	Policy number	Company

5. Account information

Complete this section if you are requesting electronic funds transfer (EFT) for premium payment.

Include a voided check with the application.

Draft date cannot be on the 29th, 30th or 31st of the month. Requesting to have a draft date more than 15 days greater than the policy's paid to date will draft a month in advance.

Proposed insured's name

▪

Account owner name, if different than proposed insured's

▪

Account owner relationship to proposed insured: ◯ Business owned by proposed insured ◯ Living trust ◯ Employer ◯ Power of Attorney ◯ Conservator/guardian ◯ Family member; specify ▪

Financial institution name

▪

◯ Checking ◯ Savings

Routing number

▪

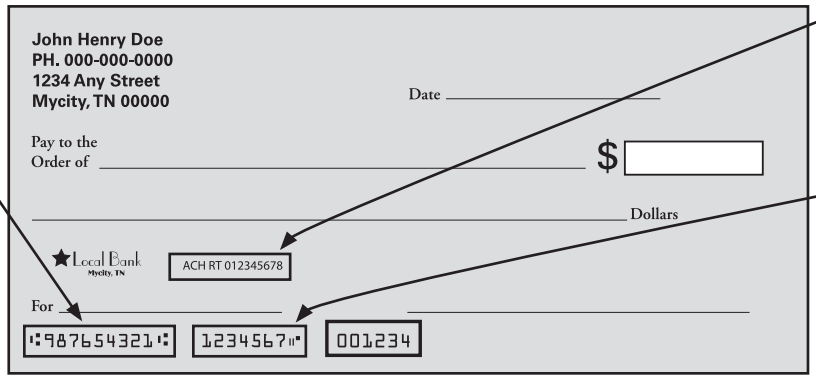
Account number

▪

Requested EFT draft date

▪

This is an example of a personal check. A business check may be different.



For all other checks, use the nine-character bank **routing number**, which appears between the ⑆ symbols, usually at the bottom left corner of the check.

For checks with an **ACH RT (Automated Clearing House Routing) number**, please use this number.

The **account number** is up to 17 characters long and appears next to the ⑈ symbol at the bottom of the check and usually to the right of the bank routing number.

6. Electronic funds transfer (EFT) authorization

I understand and accept these terms and conditions:

- We are authorized to withdraw funds periodically from your account to pay insurance premiums for the insured.
- If your financial institution does not honor an EFT request, we will NOT consider your premium paid.
- If your financial institution does not honor an EFT request, we may make a second attempt within five business days.
- We have the right to end EFT payments at any time and bill you directly either quarterly or less frequently for premiums due.
- Information as to each EFT charge will be provided by entry on your account statement or by any other means provided by your financial institution. You will not receive premium notices from us.
- If you want to cancel or change this authorization, you must contact us at least three business days before a scheduled withdrawal.
- Any refund of unearned premium will be made to the policy owner or the policy owner's estate.

Signature only required if the account owner is different than the proposed insured.

Signature of account owner Date

X ▪

7. Applicant

I (We) hereby apply to Continental Life Insurance Company of Brentwood, Tennessee for a policy to be issued in reliance on my written answers to the questions on this application. I (We) have read and understand all statements and answers and certify that to the best of my knowledge and belief, they are true, complete and correctly recorded. I (We) acknowledge that I (we) have received an outline of coverage for the policy applied for, a Specified Disease Insurance Buyer's Guide, and if 65 years of age or older, *A Guide to Health Insurance for People with Medicare* and a Non-Duplication of Medicare Disclosure.

I (We) agree (1) this application and any policy issued will constitute the entire contract of insurance and the Company will not be bound in any way by any statements, promises or information made or given by or to any agent or other person at any time unless the same is in writing and submitted to the Company at its Home Office and made a part of such contract. Only a Company Officer can make, modify or discharge contracts or waive any of the Company's rights or requirements and then only in writing; and (2) this application shall not be approved until the first premium is paid, there has been no change in my health as stated in the application and a policy has been issued by the Company.

I (We) understand and agree that, if I (we) choose to pay my premium by electronic funds transfer (EFT) from my checking or savings account, I am (We are) accepting the terms and conditions of the EFT authorization attached to this application.

I (We) understand that if any answers on this application are incorrect, incomplete or untrue, Continental Life Insurance Company of Brentwood, Tennessee has the right to adjust my premium, reduce my benefits or rescind the policy.

No person to be covered for specified disease may also be covered by any Title XIX program, designated as Medicaid or any similar name.

The policy provides limited benefits. Review your policy carefully.

Applicant signature	Date signed
X	.
Spouse signature *If applicable*	Date signed
X	.

8. Privacy notice

Although your application is our initial source of information, we may collect information including health history and medical records from persons other than you, and we may conduct a telephone interview with you. Continental Life Insurance Company of Brentwood, Tennessee, its affiliates, or its reinsurer(s) may also in certain circumstances release information collected by us to third parties without authorization from you. Upon written request, we will provide you with the information contained in your file. Medical information will be disclosed to you only through the medical professional you designate. Should you wish to request correction, amendment or deletion of any information in your file, which you believe inaccurate, please contact us and we will advise you of the necessary procedures.

9. Producer compensation

When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our Companies, or for the percentage of completed sales. Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

10. Agent

All information **must** be completed.

Please list any other medical or health insurance policies sold to the Proposed Insured.

1. List policies sold which are still in force

   ▪ .....

   ▪ .....

2. List policies sold in the past 5 years which are no longer in force

   ▪ .....

   ▪ .....

I certify that:

1. I have accurately recorded the information supplied by the applicant.
2. The application was provided to the applicant to review and the applicant has been advised that any false statement or misrepresentation in the application may result in an adjustment of premium, reduction of benefits or rescission of the policy.
3. I have provided an outline of coverage for the policy applied for, and if 65 years of age or older, *A Guide to Health Insurance for People with Medicare* and a Non-Duplication of Medicare Disclosure to applicant prior to completing the application.

The writing number reflects where commissions will be paid.

Agent name *Printed*	Writing number (agent or company)
▪	▪
Agent signature	State license ID number (for FL only)
X	▪
Phone	E-mail
▪	▪

11. Agent request to split commissions

This section must be completed with this application in order to split commissions.

If this application results in an issued policy through Continental Life Insurance Company of Brentwood, Tennessee (CLI), the agents listed below have agreed to split the commissions earned on the policy.

- Both agents must be properly licensed and appointed with CLI in the policy's state of issue.
- Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains inforce.
- The percentage of the premium split can be for any amount but must be stated in whole numbers and total 100%. (For example, the percentage for the premium split can be from 1% to 99% but cannot be 0% or 100%.)
- Calculation of each agent's commissions are based on their respective CLI commission schedule.

Agent Information *Print*

Writing Agent		Percentage
▪		▪ %
Secondary Agent	**Writing number**	**Percentage**
▪	▪	▪ %

By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.

Writing Agent Signature

X .....

12. Fraud warnings

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or combination thereof.

Arkansas and Louisiana and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of the insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine and Tennessee and Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio: 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 false or a deceptive statement is guilty of insurance fraud.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: 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, which is a crime and subjects such person to criminal and civil penalties.

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An Aetna Company

P.O. Box 14399
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800-264-4000
aetnaseniorproducts.com
office hours 7:00 a.m. - 7:00 p.m. CST

Initial premium receipt

from Continental Life Insurance Company of Brentwood, Tennessee

- Print clearly and use blue or black ink.
- Applicant keeps this receipt for their records.
- Be sure that all required sections of the application are completed. Any incomplete or missing information could delay processing of your application.

Initial premium receipt

Applicant name *Printed*

Date of application *mm/dd/yyyy*

Electronic funds transfer (EFT) draft amount
$

Initial modal premium collected/drafted
$

Electronic funds transfer (EFT) draft date

This acknowledges receipt of the initial premium in connection with your application for a Continental Life Insurance Company of Brentwood, Tennessee First Diagnosis Cancer or First Diagnosis Cancer and Heart Attack or Stroke insurance policy.

Agent name *Printed*

Phone

Signature of agent

X

- Payment will be refunded for any coverage not issued.
- A recorded telephone interview may be necessary as part of the underwriting on your application for insurance.
- All premium payments must be made payable to Continental Life Insurance Company of Brentwood, Tennessee.
- DO NOT make any check payable to the agent and do not leave the payee blank on the check.

A. If this payment equals the full, initial premium for the mode of premium payment selected by the applicant(s); and B. if the answers are true and correct in the application and if Continental Life Insurance Company of Brentwood, Tennessee issues a policy according to its rules, limits, and standards for the plan and amount applied for by the applicant(s); then this payment shall be applied to the payment of the first premium of the issued policy. No policy shall be effective until it has actually been issued by Continental Life Insurance Company of Brentwood, Tennessee.

Thank you for choosing
Continental Life Insurance Company of Brentwood, Tennessee!

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