

**APPLICATION FORM FOR  
CANCER INDEMNITY INSURANCE WITH OPTIONAL RIDERS**

**TIME INSURANCE COMPANY**

**PLEASE PRINT IN BLACK INK**

**TYPE OF ACTIVITY**

New       Change       Conversion       Reinstatement      Policy Number \_\_\_\_\_

**PERSON(S) PROPOSED TO BE INSURED**

Last Name (Applicant)	First Name	M.I.	Sex	Birth date MM/DD/YYYY	Social Security #	Height	Weight	Tobacco User Refer to #2a
								<input type="checkbox"/> Yes <input type="checkbox"/> No
(Spouse)								<input type="checkbox"/> Yes <input type="checkbox"/> No

**Dependents**

Relationship	Last Name	First Name	M.I.	Sex	Birth date MM/DD/YYYY	Full time student
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

Resident Address \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Email Address \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_ Best Time to Call \_\_\_\_\_

Name of Employer \_\_\_\_\_ Type of Business \_\_\_\_\_

Job Title \_\_\_\_\_

Job Duties \_\_\_\_\_

**PROPOSED ADDITIONS TO AN EXISTING POLICY ONLY**

Add Spouse named above       Add Dependent(s) named above

Reason(s) for addition(s) \_\_\_\_\_

Desired effective date for addition(s): \_\_\_\_\_

Complete the POLICY INFORMATION section below to indicate the type of coverage now desired. Complete the remainder of the application respective to any coverage applicable to the proposed addition.

**BILLING – to be completed by agent**

**Payroll Deduction**

Monthly       28 day  
 Other \_\_\_\_\_

**Direct**

Monthly Credit Card       Monthly EFT (Electronic Fund Transfer)  
 Annual Billing

Employee No. \_\_\_\_\_ Dept. No. \_\_\_\_\_

Billable Premium \$ \_\_\_\_\_ Premium Collected \$ \_\_\_\_\_

Sit. Code \_\_\_\_\_

**POLICY INFORMATION - to be completed by agent**

**CHECK COVERAGE DESIRED**

Individual only

One-Parent Family

Two-Parent Family

	Modal Premium	If Payroll Deduction
<input type="checkbox"/> Level 1 Policy <input type="checkbox"/> Level 2 Policy <input type="checkbox"/> Level 3 Policy	\$	<input type="checkbox"/> PreTax <input type="checkbox"/> After tax
<b>Optional Rider Coverage</b>		
<input type="checkbox"/> Specified Disease Rider	\$	
<input type="checkbox"/> Return of Premium Rider	\$	After tax only
<b>Total Premium</b>	<b>\$</b>	

**INSURANCE AND HEALTH HISTORY**

- 1a. Are you covered under another Cancer policy with:
- |  |                             |  |  |
|--|-----------------------------|--|--|
| - Time Insurance Company .....           | <input type="checkbox"/> No | <input type="checkbox"/> Yes, policy # _____ | Is this a change of that coverage?                       |
| - Union Security Insurance Company ..... | <input type="checkbox"/> No | <input type="checkbox"/> Yes, policy # _____ | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| - John Alden Life Insurance Company..... | <input type="checkbox"/> No | <input type="checkbox"/> Yes, policy # _____ | <input type="checkbox"/> No <input type="checkbox"/> Yes |

1b. Does this policy replace any other health policy you currently have? .....  Yes  No

- |   |  |  |
|---|--|--|
|   | <b>Applicant</b>   | <b>Applicant's Spouse</b>                                |
| 2a. Has anyone proposed to be insured smoked cigarettes or used tobacco in any form or nicotine substitute within the past year? .....          | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2b. Has anyone proposed to be insured EVER smoked cigarettes or used tobacco products? If yes, indicate who, amount per day and year quit. .... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Details: \_\_\_\_\_

3. Has anyone proposed to be insured:
- a. received a health screening that tests for the presence of cancer (such as a mammogram, Pap smear, PSA, chest x-ray or colonoscopy) in the past 10 years for which you have not received the results? .....  Yes  No
  - b. been advised by a member of the medical profession to receive a follow-up test for the presence of cancer in the past 10 years, for which you have not received the results? .....  Yes  No
  - c. received abnormal test results from a health screening test for evaluation of the presence of cancer in the past 90 days? .....  Yes  No

If "Yes" to 3a – 3c, was it the  Applicant  Spouse  Child (name the child(ren) on the line below:)

Any individual(s) indicated above in 3 will not be covered under the policy.

4a. In the past 10 years, has anyone proposed to be insured been diagnosed or treated for cancer of any type or form?  Yes  No

If you answered "Yes" to 4a, complete the rest of the Cancer History section, otherwise skip to 5.

4b. Was any cancer referred to above in 4a an internal cancer (which includes melanomas Clark's Level III or higher, or a Breslow level greater than 1.5mm) **diagnosed or treated** by a member of the medical profession **within the last ten years or for which preventive Hormonal Therapy has been received within the last 12 months?** .....  Yes  No  
If "Yes", was it the  Applicant  Spouse  Child (name the child(ren) on the line below:)

**Any individual(s) indicated above in 4b will not be covered under the policy.**

4c. Was any cancer referred to above in 4a an internal cancer (which includes melanomas Clark's Level III, or higher or a Breslow level greater than 1.5mm) **last diagnosed or treated more than ten years ago and for which no preventive Hormonal Therapy has been received within the last 12 months?** .....  Yes  No  
If "Yes", was it the  Applicant  Spouse  Child (name the child(ren) on the line below:)

**Please complete a Cancer History Form provided by your agent on each individual listed above in 4c.**

4d. Was any cancer referred to in 4a a Skin cancer (which includes melanomas Clark's Level I or II, or a Breslow level less than or equal to 1.5mm) **diagnosed or treated within the last ten years?** .....  Yes  No  
If "Yes", was it the  Applicant  Spouse  Child (name the child(ren) on the line below:)

**The agent will complete a policy Amendment Rider for any individual identified in 4d. The Amendment Rider will exclude benefits for the individual(s) for the treatment of skin cancer.**

4e. Was any cancer referred to in 4a a skin cancer (which includes melanomas Clark's Level I or II, or a Breslow level less than or equal to 1.5mm) **last diagnosed or treated more than ten years ago?** .....  Yes  No  
If "Yes", was it the  Applicant  Spouse  Child (name the child(ren) on the line below:)

**Any individual identified above in 4e will NOT require a policy Amendment Rider. Benefits may be payable under the policy for the individual(s) for the treatment of skin cancer.**

**COMPLETE THIS SECTION ONLY IF APPLYING FOR A CONVERSION**

5. **If you answered "yes" to 4a above, answer this question. Otherwise skip to 6.**  
Has any person proposed to be insured received benefits, other than Wellness Benefits, under your existing Time Insurance Company Cancer policy in the last ten years? .....  Yes  No  
If "Yes", was it the  Applicant  Spouse  Child (name the child(ren) on the line below:)

**Any individual(s) indicated above in 5 will not be covered under the policy.**

6. **PLEASE READ IF APPLYING FOR A CONVERSION.** If this is an application for a conversion, the following conditions apply: (a) If cancer is diagnosed between the date this application is signed and the Effective Date of the policy shown in the Policy Schedule, the policy for which this application is made will be void and coverage will continue under the terms of the previous policy, which may remain in force. Any benefits that may be due will be paid under the previous policy. (b) The waiting period provision will run from the Effective Date of the original policy, and the original policy will be terminated as of the Effective Date of the new Policy. Any premium paid on the original policy that is unearned as of the Effective Date of the new policy will be applied to the new policy.

**IF APPLYING FOR SPECIFIED DISEASE BENEFIT RIDER, PLEASE COMPLETE 7**

7. In the past ten years, has anyone proposed to be insured been diagnosed as having or treated for or been advised to receive a follow-up test for which you have not received the results for the presence of any of the diseases listed below? .....  Yes  No

- Adrenal hypofunction (Addison’s disease)
- Amyotrophic lateral sclerosis (ALS or Lou Gehrig’s disease)
- Anthrax
- Botulism
- Bubonic plague
- Cerebral palsy
- Cholera
- Cystic Fibrosis
- Diphtheria
- Encephalitis (including Encephalitis contracted from West Nile virus)
- Huntington’s chorea
- Legionnaire’s disease
- Lyme disease
- Malaria
- Meningitis (bacterial)
- Multiple Sclerosis
- Muscular Dystrophy
- Myasthenia gravis
- Necrotizing fasciitis
- Osteomyelitis
- Polio
- Rabies
- Reye’s syndrome
- Severe Acute Respiratory Syndrome (SARS)
- Scarlet fever
- Scleroderma
- Systemic lupus
- Tetanus
- Toxic shock syndrome
- Tuberculosis
- Tularemia
- Typhoid Fever
- Variant Creutzfeldt-Jacob disease (mad cow disease)
- West Nile virus
- Yellow fever

**If you responded “Yes” to 7 above, please complete the details below.**

Name	Relationship	Condition(s) from above

**The agent will complete a policy Amendment Rider for any individual identified above in 7 proposed to be insured under the Specified Disease Benefit Rider. The Amendment Rider will exclude benefits for the condition(s) identified above in 7 for the respective individual(s).**

**PROPOSED POLICYOWNER'S AGREEMENT**

**I represent to the best of my knowledge and belief, that all statements and answers on this application form are complete and true. The application form and any amendments shall be the basis for the contract. I also agree that:**

The policy, if approved by Time Insurance Company, will have the Effective Date recorded on the Policy Schedule by Time Insurance Company.

I acknowledge receiving the following, if required:

- Fair Credit Reporting Act Pre-Notification
- Outline of Coverage (if required by state law)
- the Abbreviated Notice of Insurance Information Practices
- the notification regarding the Medical Information Bureau
- Guide to Health Insurance for People with Medicare

I understand that the premium amount listed on this application represents the premium amount that my employer will remit on my behalf if I select payroll deduction as the method of premium payment. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me by my agent.

I have read, or had read to me, the completed application and realize that policy issuance is based upon statements and answers provided and any other pertinent information that may be required for proper underwriting. The answers are complete and true to the best of my knowledge and belief. I understand and acknowledge that any fraudulent statement or material misrepresentation on the application and/or any amendments may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provisions in the policy.

- A.M.
- P.M.

\_\_\_\_\_  
 Signature of proposed Policyowner                      Date signed                      Time Signed                      City & State

**AGENT INFORMATION AND REVIEW**

**Agency Name and Time Agency Number** \_\_\_\_\_

**Agent Name and Time Agent Number** \_\_\_\_\_

Agent Phone Number (     ) \_\_\_\_\_ Agent Fax Number (     ) \_\_\_\_\_

General Agent is located in the state of \_\_\_\_\_

I certify that:

- I personally saw the applicant. The applicant was asked each required question and the answer truly and accurately recorded on the application in the respective response area. The answers are true to the best of my knowledge.
- The application was completed by the applicant or applicant's representative and the answers are true to the best of my knowledge.

\_\_\_\_\_  
 Licensed Resident Agent's Signature                      Date Signed                      Initial here if you witnessed the signing of this form by the proposed Policyowner.

## **FAIR CREDIT REPORTING ACT AND PRIVACY PRE-NOTIFICATION**

Thank you for considering Time Insurance Company as your insurance carrier. Your enrollment form will be processed as quickly as possible. Public Law 91-508 and state privacy acts require that we advise you that an investigative consumer report may be made in connection with this application form which will provide applicable information concerning character, general reputation, personal characteristics and mode of living. The information for this report may be obtained through telephone or personal interviews with you, your friends, neighbors and associates. You may request an interview in connection with the preparation of the report. Upon written request, you are entitled to receive a copy of the report.

## **ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES**

Information collected by us and used to issue an insurance policy or certificate may be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, PO Box 1739, Ft. Mill, SC 29716-1739.

## **FRAUD WARNING**

Any person who, with intent to defraud or knowingly presents false information on an application for insurance, or files a false or fraudulent claim for payment of a loss or benefit, is guilty of insurance fraud. Any person found guilty of insurance fraud may be subject to fines and confinement in prison.

## **NOTIFICATION REGARDING THE MEDICAL INFORMATION BUREAU**

Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request form from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction on accordance with the procedures set forth in the federal fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. Time Insurance Company or its reinsurers may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may also apply for life, disability or medical insurance, or to whom a claim for benefits may be submitted.

# CANCER HISTORY FORM

TIME INSURANCE COMPANY

PLEASE PRINT IN BLACK INK

## POLICY INFORMATION

Policyowner's Name \_\_\_\_\_ Policy Number \_\_\_\_\_  
(if the policy has not yet been issued, name of Applicant to be the Policyowner) (complete if the policy has been issued)

Resident Address \_\_\_\_\_  
Street  
\_\_\_\_\_  
City State ZIP

## APPLICATION GUIDELINES

Applicants or family members with a history of a malignant condition may apply for our cancer policy, providing there has been no recurrence or treatment for the malignancy within the ten years preceding the application date and no preventive Hormonal Therapy has been received within the last 12 months.

If a person qualifies under these guidelines, both that person and a physician must complete their respective parts of this form. (A separate form must be completed for each person with cancer history proposed to be insured.)

If the physician charges a fee for reviewing records and completion of the Cancer History Statement, the applicant is responsible for the charges. The application and this completed form (which is considered part of the application) are subject to underwriting by our administrative office. If the application is not approved, any premiums paid will be refunded.

It is not necessary for this form to be completed by the physician who treated the person for cancer. Another physician can complete this form, based upon history as disclosed to him or her by the person with cancer history and based upon an examination of that person. The physician completing this form must have performed the examination within 12 months prior to the date of the application.

## AUTHORIZATION

Name of person, proposed to be insured, with cancer history \_\_\_\_\_

Name of **physician** authorized to complete Cancer History Statement \_\_\_\_\_

I hereby authorize the physician named above to disclose information to Time Insurance Company concerning my medical history and present medical condition.

\_\_\_\_\_  
Signature of person with cancer history (parent or guardian in case of a minor) Date

\_\_\_\_\_  
Signature of Policyowner (if other than person above) Date

PLEASE PRINT IN BLACK INK

**CANCER HISTORY STATEMENT – to be completed by physician**

I, \_\_\_\_\_, have reviewed the medical history of \_\_\_\_\_  
Physician completing the form Name of proposed insured with cancer history

This person had internal cancer first diagnosed on \_\_\_\_\_ as \_\_\_\_\_ of the  
Month/Day/Year Type of cancer  
\_\_\_\_\_  
Location of cancer

The last treatment for cancer was on \_\_\_\_\_ . Based on my review of the medical history and  
Month/Day/Year

the last examination on \_\_\_\_\_ , I believe there has been no recurrence of or treatment for cancer in  
Month/Day/Year

the last ten years. The last date of preventative hormonal therapy (if applicable) was \_\_\_\_\_ .  
Month/Day/Year

Physician's Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Physician's Address \_\_\_\_\_  
Street  
\_\_\_\_\_  
City State ZIP

\_\_\_\_\_  
Physician's signature Date

**(PROPOSED) POLICYOWNER'S AGREEMENT – to be signed after all information is complete**

I understand that \_\_\_\_\_  
Name of person with cancer history

will **NOT** be eligible to receive a First-Occurrence Benefit from Time Insurance Company for a recurrence, extension, or metastatic spread of any internal cancer diagnosed prior to the effective date of coverage.

I have read, or had read to me, the completed Cancer History Form, and I certify the statements and answers provided herein are complete and true.

\_\_\_\_\_  
Signature of person with cancer history (parent or guardian in case of a minor) Date

\_\_\_\_\_  
Signature of (proposed) Policyowner (if other than person above) Date

**NOTICE TO APPLICANT REGARDING REPLACEMENT  
OF ACCIDENT AND HEALTH INSURANCE**

**Complete this notice if response is "Yes" to application question:**

1. "Does this policy replace any other... policy you currently have?"

**Provide one copy to applicant and one to Time Insurance Company with application.**

According to your application, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by Time Insurance Company. 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, (pre-existing conditions) 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 an 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)

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(Applicant's printed name)

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(Applicant's Social Security Number)