

**APPLICATION FORM FOR
HOSPITAL 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 Individual and Spouse
 One-Parent Family Two-Parent Family

	Sickness Elimination Period	Premium	If Payroll Deduction
<input type="checkbox"/> Level 1 Policy	<input type="checkbox"/> 0 Days	\$	<input type="checkbox"/> PreTax
<input type="checkbox"/> Level 2 Policy	<input type="checkbox"/> 1 Days		<input type="checkbox"/> After tax
<input type="checkbox"/> Level 3 Policy	<input type="checkbox"/> 3 Days		
	<input type="checkbox"/> 7 Days		
	<input type="checkbox"/> 14 Days		

Optional Rider Coverage

	Units*	Premium
<input type="checkbox"/> Additional Initial Hospitalization Rider		\$

**Note: Each unit is equal to a \$200 benefit.*

	Premium
<input type="checkbox"/> Accident Rider	\$
<input type="checkbox"/> Accident and Sickness Rider	
<input type="checkbox"/> Hospital Intensive Care Rider Level 1	\$
<input type="checkbox"/> Hospital Intensive Care Rider Level 2	
<input type="checkbox"/> Hospital Intensive Care Rider Level 3	
Total Premium	\$

CURRENT COVERAGE

- 1a. Are you covered under another Hospital Indemnity 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. List all Hospital Indemnity policies you currently have in force with any insurance company. Please provide the insurance company name, policy number and daily benefit amounts:
-
-

TOBACCO USE

- | | Applicant | Applicant's Spouse |
|---|--|--|
| 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 |

BASE COVERAGE

3. Is anyone proposed to be insured currently confined in a hospital or nursing home, or has a Physician recommended hospitalization? Yes No

4. Has anyone proposed to be insured been confined in a hospital for 14 or more hours within the last 36 months due to any of the following? Yes No
(Check all that apply.)
- | | | |
|---|---|---|
| <input type="checkbox"/> Angina (heart-related chest pain) | <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Peripheral vascular disease (circulatory problems) |
| <input type="checkbox"/> Cancer (other than nonmelanoma skin cancers) | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cerebral vascular insufficiency | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Transient Ischemic Attack (TIA / ministroke) |
| | <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Ulcerative colitis |
5. Has anyone proposed to be insured been confined in a hospital for 14 or more hours within the last 12 months because of any of the following? Yes No
(Check all that apply.)
- | | |
|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver disease or disorder (excluding Hepatitis A) |
| <input type="checkbox"/> Chronic obstructive pulmonary disease | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Sickle-cell anemia |
6. Has anyone proposed to be insured ever been diagnosed as having or treated for any of the following? Yes No
(Check all that apply.)
- | | |
|---|--|
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Senile dementia |
| <input type="checkbox"/> Insulin-dependent diabetes | <input type="checkbox"/> Systemic lupus |
| <input type="checkbox"/> Kidney disease (not including kidney stones) | <input type="checkbox"/> Uncorrected congenital heart defect (excluding mitral valve prolapse) |
7. Has anyone proposed to be insured been diagnosed with or treated for AIDS or tested positive for any human immunodeficiency virus (HIV) or any form of pathogenic human T-cell lymphotropic virus (HTLV)? Yes No

Acquired Immune Deficiency (AIDS) is caused by a virus known by several names i.e. Human Immunodeficiency Virus (HIV); Human T-Lymphotropic Virus Type III (HTLV-III); Lymphadenopathy Associated Virus (LAV); and AIDS Related Virus (ARV). It may take anywhere from a few months to several years or more after initial infection with HIV for AIDS or ARC to develop. AIDS is a condition that breaks down part of the body's immune system making it difficult for the body to fight off infection and disease. AIDS Related Complex (ARC) is a condition with signs and symptoms which may include generalized Lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression or other psychoneurotic disorder with no known cause.

8. If you responded "Yes" to any of 3 – 7, please provide the name and relationship of the person(s) to whom it applies.

Any person(s) listed in 8 will not be covered under this policy or any rider.

CONVERSION - Please read this section if you are applying for a conversion.

NOTE: If this is an application for a conversion of coverage, the following conditions will apply: (a) If 3, 4, 5, 6, or 7 above is answered "Yes" the policy for which this application is made for the person(s) identified above in 8 will be void, and coverage will continue under the terms of the previous policy, which may remain in force. Benefits that may be due any person(s) listed above in 8 will be paid under the previous policy. (b) Any person(s) not listed above in 8, if eligible, will be covered under the new policy. (c) The waiting period and the Time Limit on Certain Defenses 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. (d) The Pre-existing Conditions provision in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the Pre-existing Conditions provision in the new policy will run from the new policy's Effective Date.

HOSPITAL INTENSIVE CARE BENEFITS RIDER – complete if you are applying for the rider.

9. Has any person proposed to be insured by the Hospital Intensive Care Rider ever been treated for: a heart attack; a heart condition; heart trouble; any abnormality of the heart (including artery disease); diabetes; or high blood pressure not controlled by medication? Yes No
10. If you responded "Yes" in 9, please provide the name and relationship of the person(s) to whom it applies.

The agent will complete a Medical Condition Exclusion Rider for any person identified in 10 proposed to be insured under the Hospital Intensive Care Rider. The Medical Condition Exclusion Rider will exclude benefits for that person for all heart-related conditions and limit Hospital Intensive Care coverage for all other conditions.

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

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 Number _____

Agent Name and Time 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.