

Application for Hospital Indemnity
Kanawha Insurance Company
 - NEWBORN -

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CHILD ADDITION TO POLICY #

PLEASE INDICATE: NEW COVERAGE CHANGE TO EXISTING COVERAGE CONVERSION

Person(s) Proposed for Coverage

Primary Insured (Please Print)

First Name MI Last Name Suffix
 Birthdate (MM/DD/YYYY) Height (Ft-In) Weight Social Security Number Gender
 Address (Street or R.R.)
 City State ZIP Code
 Home Telephone

Spouse

Spouse Name (First Name, MI, Last Name) (If proposed for coverage) Suffix
 Birthdate (MM/DD/YYYY) Height (Ft-In) Weight Social Security Number Gender

Child One

Child Name (First Name, MI, Last Name) (If proposed for coverage) Suffix
 Birthdate (MM/DD/YYYY) Height (Ft-In) Weight Social Security Number Gender

Child Two

Child Name (First Name, MI, Last Name) (If proposed for coverage) Suffix
 Birthdate (MM/DD/YYYY) Height (Ft-In) Weight Social Security Number Gender

Child Three

Child Name (First Name, MI, Last Name) (If proposed for coverage) Suffix
 Birthdate (MM/DD/YYYY) Height (Ft-In) Weight Social Security Number Gender

1664 UT

9581642577

Payor Information

Payor Information (First, MI, Last Name) (If different than the Proposed Insured)

Suffix

Grid for Payor Name

Social Security Number

Grid for Social Security Number

Address (Street or R.R.)

Grid for Address

City

State

ZIP Code

Grids for City, State, and ZIP Code

Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud.

I have read or had read to me all the questions on this Application and I represent the answers and any information provided are correct and complete to the best of my knowledge and belief. I also realize that any false statements or misrepresentation may result in loss of coverage under the policy subject to the time limit on certain defenses or incontestability provisions of the policy. I understand and agree that the policy will not take effect unless it is issued by Kanawha Insurance Company, the total modal premium must accompany Application, and any check, bank draft or credit card payment is honored on first presentation. No agent or producer has the authority to waive any of the conditions or questions in this Application.

I acknowledge, if required in my state, that I have been furnished:

Outline of Coverage Medicare Buyer's Guide (If age 65 or over)

Signed At _____ City

UT State

X _____ Signature of Primary Insured/Owner (Parent or Guardian if Child only coverage)

_____/_____/_____ Date (MM/DD/YYYY)

FOR INSURANCE PRODUCER'S USE ONLY

I certify any information recorded by me on this Application is true and accurate to the best of my knowledge and belief.

Will this insurance replace any existing insurance?..... Yes No

Date (MM/DD/YYYY)

Signature of Licensed Insurance Producer Gregory W. Davies

Grid for Date

Printed Name of Licensed Insurance Producer Gregory W. Davies

Insurance Producer Number % Credit

Grid for Insurance Producer Number and % Credit (1392992, 100)

Insurance Producer Number % Credit

Grid for Insurance Producer Number and % Credit

Insurance Producer Number % Credit

Grid for Insurance Producer Number and % Credit

AUTHORIZATION FOR AUTOMATIC PAYMENT BY BANK DRAFT

Attach Voided Check

Name of Depositor (First, MI, Last Name) (Attach Voided Check) Suffix

Route and Transit Number Account Number

Bank Name and Address

Debit on the day of the month (1-28 only; 29, 30, 31 not available). **If no election is made, debits will be made on the day of Policy.**

As a convenience to me, I request and authorize **KANAWHA INSURANCE COMPANY** to make deductions automatically every payment period for payments of premiums from my: savings account checking account

1. Each debit shall constitute proper notice of premium due and will be made on the day selected above or, if no day is selected, the day of Policy.
2. This Authorization shall not become effective unless and until the coverage is issued.
3. This Authorization shall not be construed as modifying any provisions of the coverage.
4. Kanawha shall not incur any liability if a draft is returned unpaid by the bank. Drafts which do not clear within the time stipulated in the Policy for payment of premium shall constitute nonpayment of premiums and coverage shall lapse subject to nonforfeiture provisions.
5. This Authorization may be discontinued by Kanawha or by the Undersigned at any time within FIVE (5) business days prior to the debit date. Upon termination of this Authorization, the premiums on the Policy covered will be payable annually.
6. Kanawha will notify me TEN (10) days prior to any changes in payment amounts.

Signature of Depositor _____ Date (MM/DD/YYYY) / /

CREDIT CARD INFORMATION

Card Holder Information

Credit Card Number Expiration Date (MM/YY) Card Type

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Visa Mastercard

3 or 4-digit security code found on the back of most cards:

Signature of Card Holder _____ Date (MM/DD/YYYY) / /

Name as it appears on the credit card statement (If different from Proposed Insured).

Card Holder (First Name, MI, Last Name) Suffix

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All charges will be made on the day of Policy.

As a convenience to me, I request and authorize **KANAWHA INSURANCE COMPANY** to charge my credit card every payment period for payment of premiums.

1. Each charge shall constitute proper notice of premium due.
2. This Authorization shall not become effective unless and until the Policy is issued.
3. This Authorization shall not be construed as modifying any provisions of the Policy.
4. Kanawha shall not incur any liability if the credit card company does not honor the charge and the Policy shall lapse subject to nonforfeiture provisions.
5. This Authorization may be discontinued by Kanawha or by the undersigned at any time within FIVE (5) business days prior to the payment date. Upon termination of this Authorization, premiums for the Policy will be payable annually.
6. Kanawha will notify me TEN (10) days prior to any changes in payment amounts.

Signature of Card Holder _____ Date (MM/DD/YYYY) / /

Newborn child addition

Coverage Change Form

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Kanawha Insurance Company, [P.O. Box 7200, Lancaster, SC 29721]

Insured's Name _____ Policy Number _____
 Owner's Name _____ Owner's Social Security Number _____
 Owner's Address _____
 City _____ State _____ ZIP+4 _____
 Owner's Telephone _____

Section A - C require that the health questions in Section D be completed (unless otherwise noted)

Section A: Change dividend option

- Purchase Additional Paid-up Insurance
- Purchase One Year Term
- Left to Accumulate*
- Paid in Cash*
- Reduced Premium*

* Health questions in Section D not required

Section B: Adding benefits and riders

- Insured's Waiver of Premium
- Owner/Applicant's Waiver of Premium
- Accidental Death & Dismemberment
- Other Coverage Please add my newborn

Section C: Remove

- Rating
- Exclusion
- Both

For (Insured's Name) _____

to my policy retro to date of birth;

The representations made in Section D apply to each person proposed for coverage.

Section D: Health and Life Insurance

The undersigned hereby represents that:

1. Within the past five years, or the period since the date of issue of the policy, whichever is shorter, has any person: **YES** **NO**

a. had any injury, disease or disorder?	<input type="checkbox"/>	<input type="checkbox"/>
b. consulted, been treated or examined by a physician or other medical practitioner?	<input type="checkbox"/>	<input type="checkbox"/>
c. been advised to enter, or in a hospital or health care facility for observation, diagnosis, operation or treatment? ..	<input type="checkbox"/>	<input type="checkbox"/>
d. ever had or been diagnosed as having an Immune Deficiency Disorder, AIDS or AIDS Related Complex (ARC)? ..	<input type="checkbox"/>	<input type="checkbox"/>
e. received advice or treatment for the use of alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
f. been declined, postponed, charged an extra premium, refused reinstatement, been issued a policy with an exclusion rider, or offered a policy on a basis different from that applied for?	<input type="checkbox"/>	<input type="checkbox"/>
g. engaged in aviation as a pilot or crew member?	<input type="checkbox"/>	<input type="checkbox"/>
h. changed customary occupation?	<input type="checkbox"/>	<input type="checkbox"/>
2. Give full details to "Yes" answers from the above statements 1a - 1h. Always indicate the name of the person, disease, injury or disorder, dates, results of treatment, names and addresses of each physician and each hospital: _____

3. Change in weight: (disregarding a child's normal growth). If weight has changed, give present height and weight, amount of weight lost or gained, and give reason for change _____

4. Used tobacco in any form in the last twelve months? Yes No

Health q's
are N/A
since the
newborn is
being added
w/in 30
days of
birth
↓

N/A
↓

6106 06/10

Kanawha Insurance Company is a Humana company.

GCA09JLHH

MIB Disclosure Notice – Detach and Give to Proposed Insured

Information regarding your insurability will be kept confidential. Kanawha Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life and health 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 from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is [50 Braintree Hill Park[,] [Suite 400], [Braintree, MA 02184-8734], email address [www.mib.com] and telephone number [(781) 751-6000]. Kanawha Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

State Specific Fraud Warning Statements

Arkansas

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

California

For your protection, California law requires the following to appear on this form:

Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state 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 an 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 the 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

WARNING: 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 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.

Louisiana

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

Maryland

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

North Carolina

Any person with the intent to injure, defraud, or deceive an insurer or insurance claimant is guilty of a crime (Class H felony) which may subject the person to criminal and civil penalties.

Ohio

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.

Oklahoma

WARNING: 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.

Rhode Island

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

Tennessee, 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 include imprisonment, fines, and denial of insurance benefits.

State Specific Authorization Provisions

Arizona

By this form (or photocopy of it), which is valid for 30 months from the date shown below (180 days in the case of HIV related information), I/We authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, pharmacy, pharmacy benefit manager or other pharmacy related services organization, insurance company, the Medical Information Bureau, or other person, organization, or institution, that has any records or knowledge of me, my spouse or my child(ren) for whom insurance Application is made, or my health, my spouse's or my child(ren)'s health, to give to Kanawha Insurance Company, or its reinsurers, any such information and to testify as to such information, all to the extent permitted by law. I understand that such information will be used by Kanawha Insurance Company for the purpose of evaluating my Application for insurance.

I/We understand that I/We have the right to revoke this Authorization in writing, at any time, by providing written request for revocation to: Kanawha Insurance Company at [210 South White Street, Lancaster, SC 29720], Attention: Underwriting Department. I/We understand that a revocation is not effective to the extent that Kanawha Insurance Company has relied upon information disclosed prior to the revocation. I/We understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

Florida, Kentucky, Nebraska, Oklahoma, Oregon, West Virginia and Wyoming

By this form (or photocopy of it), which is valid for 24 months from the date shown below, I/We authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, pharmacy, pharmacy benefit manager or other pharmacy related services organization, insurance company, the Medical Information Bureau, or other person, organization, or institution, that has any records or knowledge of me, my spouse or my child(ren) for whom insurance Application is made, or my health, my spouse's or my child(ren)'s health, to give to Kanawha Insurance Company, or its reinsurers, any such information and to testify as to such information, all to the extent permitted by law. I understand that such information will be used by Kanawha Insurance Company for the purpose of evaluating my Application for insurance.

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Minnesota

By this form (or photocopy of it), which is valid as long as the individual is insured, I/We authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, pharmacy, pharmacy benefit manager or other pharmacy related services organization, insurance company, the Medical Information Bureau, or other person, organization, or institution, that has any records or knowledge of me, my spouse or my child(ren) for whom insurance Application is made, or my health, my spouse's or my child(ren)'s health, to give to Kanawha Insurance Company, or its reinsurers, any such information and to testify as to such information, all to the extent permitted by law. I understand that such information will be used by Kanawha Insurance Company for the purpose of evaluating my Application for insurance.

I/We understand that I/We have the right to revoke this Authorization in writing, at any time, by providing written request for revocation to: Kanawha Insurance Company at [210 South White Street, Lancaster, SC 29720], Attention: Underwriting Department. I/We understand that a revocation is not effective to the extent that Kanawha Insurance Company has relied upon information disclosed prior to the revocation. I/We understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

Missouri

I acknowledge that within 60 days of Home Office receipt, Kanawha Insurance Company will advise whether this application has been accepted or rejected. By this form (or photocopy of it), which is valid for 30 months from the date shown below, I/We authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, pharmacy, pharmacy benefit manager or other pharmacy related services organization, insurance company, the Medical Information Bureau, or other person, organization, or institution, that has any records or knowledge of me, my spouse or my child(ren) for whom insurance Application is made, or my health, my spouse's or my child(ren)'s health, to give to Kanawha Insurance Company, or its reinsurers, any such information and to testify as to such information, all to the extent permitted by law. I understand that such information will be used by Kanawha Insurance Company for the purpose of evaluating my Application for insurance.

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Vermont

By this form (or photocopy of it), which is valid for 30 months from the date shown below, I/We authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, pharmacy, pharmacy benefit manager or other pharmacy related services organization, insurance company, the Medical Information Bureau, or other person, organization, or institution, that has any records or knowledge of me, my spouse or my child(ren) for whom insurance Application is made, or my health, my spouse's or my child(ren)'s health, to give to Kanawha Insurance Company, or its reinsurers, any such information and to testify as to such information, all to the extent permitted by law. This authorization excludes the release of information relating to previously administered tests for HIV antibodies, T-cell counts, Acquired Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) by any medical doctor, doctor of osteopathy, physician, health care professional, hospital, clinic, medical facility, the Veterans Administration, the MIB, Inc., employer, consumer reporting agencies, other insurance company, or anyone else, with respect to previous test results, nor is Kanawha authorized to release any HIV-related information to any other person. I realize that I, or a representative on my behalf, have a right to receive a copy of this authorization.

I/We understand that I/We have the right to revoke this Authorization in writing, at any time, by providing written request for revocation to: Kanawha Insurance Company at [210 South White Street, Lancaster, SC 29720], Attention: Underwriting Department. I/We understand that a revocation is not effective to the extent that Kanawha Insurance Company has relied upon information disclosed prior to the revocation. I/We understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

Wisconsin

By this form (or photocopy of it), which is valid for 30 months from the date shown below, I/We authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, pharmacy, pharmacy benefit manager or other pharmacy related services organization, insurance company, the Medical Information Bureau, or other person, organization, or institution, that has any records or knowledge of me, my spouse or my child(ren) for whom insurance Application is made, or my health, my spouse's or my child(ren)'s health, to give to Kanawha Insurance Company, or its reinsurers, any such information and to testify as to such information, all to the extent permitted by law. Information about AIDS or HIV status is limited to a positive diagnosis made by a member of the medical profession. HIV test results received at an anonymous counseling and testing site or results from a home test kit are not subject to disclosure. I understand that such information will be used by Kanawha Insurance Company for the purpose of evaluating my Application for insurance.

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