

Hospital Cash Plan



No one plans to get sick or injured.
Be prepared if it happens to you.

HUMANA[®]
Guidance when you need it most

Humana Financial Protection Products

Hospital Cash Plan



Protect your savings from unexpected expenses.

In recent years, more than 40% of Americans have made an unexpected visit to an emergency room.* Your hard-earned savings could be at risk because of an accident or illness you have no way of predicting or preventing. Humana's **Hospital Cash Plan** is insurance that pays cash to you, or your designee, when you're sick or injured and need medical attention. Cash that can help pay for things your other insurance plans may not cover like copayments, deductibles, transportation expenses, and more ... the choices are endless.

Even if you already have insurance, this plan pays you cash for:

- ✓ Emergency room treatment for accidental injury or sickness
- ✓ Benefits for hospital confinement and outpatient surgery

Base benefits

Lump Sum for Hospital Confinement – Five Policy Options				
\$250	\$500	\$1,000	\$1,500	\$2,000
Maximum of one confinement for each insured per year				
Lump Sum for Accidental Injury and Sickness				
\$150 for each Emergency Room visit		Within 72 hours of an accidental injury		
Maximum payments per year				
• Individual – 2		• Single Parent – 4		• Family – 6
Lump Sum for Outpatient Surgery				
\$150 for each Outpatient Surgery				
Paid per admittance/visit. For multiple surgeries within one admittance/visit, policy provides one cash payment.				
Maximum payments per year				
• Individual – 2		• Single Parent – 4		• Family – 6

Optional benefits

Hospital Indemnity/ICU Daily Benefit Rider – Three Policy Options
<ul style="list-style-type: none"> • \$50/day (\$200/day if ICU) • \$100/day (\$400/day if ICU) • \$200/day (\$800/day if ICU)
Maximum of 30 days during a period of confinement resulting from injury or sickness, under the supervision of a physician, and beginning while rider is in force
Paid day one along with the lump-sum hospital confinement benefit
One period of confinement means one continuous hospital confinement or two or more hospital confinements for the same or related injury or sickness.
All hospital confinements due to the same or related cause or causes shall be considered one and the same confinement unless periods of confinement resulting there from are separated by an interval of at least 180 consecutive days between the end of one such confinement and the beginning of a subsequent such confinement.

Policy limitations Covers certain pre-existing conditions after a 12-month waiting period. Waiting periods apply to certain conditions, see policy form for details.

Hospital Cash Plan is Kanawha Insurance Company policy Form 90840 and optional rider policy Form 90841. Benefits may vary by state and may not be approved in all states. Limitations and exclusions apply. The benefits and riders offered are supplemental and not intended to cover all medical expenses. Please see actual policy for complete details. Underwritten by Kanawha Insurance Company – a member of the Humana family of companies.

* U.S. Department of Health and Human Services, Advance Data, June, 2007.



Payor Information

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

Suffix

Grid for name input

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 State

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)

Grid for Date

Signature of Licensed Insurance Producer

Printed Name of Licensed Insurance Producer

Insurance Producer Number % Credit

Grids for Insurance Producer Number and % Credit (first set)

Insurance Producer Number % Credit

Grids for Insurance Producer Number and % Credit (second set)

Insurance Producer Number % Credit

Grids for Insurance Producer Number and % Credit (third set)

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

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

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) / /