HOSPITAL INDEMNITY INSURANCE

Flexible Choice Hospital Indemnity Senior Choice Application Booklet for Iowa

- Application
- Electronic funds transfer agreement
- HIPAA notices
- Replacement notice

Together, all the way.®

Cigna®

Insured by Loyal American Life Insurance Company

912134 07/20

INDIVIDUAL HOSPITAL INDEMNITY INSURANCE POLICY

Insured by Loyal American Life Insurance Company®
PO Box 5725, Scranton, PA 18505-5725 • (866) 459-4272

Phone Verification Case # _____

Application for Insurance
(Issue Ages 50 – 85)

Section I. Coverage Options

1. Applying for: ☐ New coverage ☐ Reinstatement ☐ Change in benefit coverage
   ☐ Add rider(s) to existing policy* ☐ Add dependent(s) to existing policy*

   *Policyowner's name _____

2. Requested effective date _____

Section II. Applicant(s) applying for coverage

Last Name	First Name	M. I.	Age	Date of Birth (MM/DD/YYYY)	Gender	Social Security Number
Primary Applicant					☐ Male ☐ Female	
Spouse/Domestic Partner					☐ Male ☐ Female	
Child 1					☐ Male ☐ Female	
Child 2					☐ Male ☐ Female	
Child 3					☐ Male ☐ Female	
Child 4					☐ Male ☐ Female	

Section III. Primary Applicant's Information

Home address required:

Street/PO Box

City State ZIP code

Mailing address *(if different from home address):*

Street/PO Box

City State ZIP code

Preferred email address

Cell phone ( ) Home phone ( ) Work phone ( )

Section IV. Beneficiary Information: Please provide beneficiary information for the Primary Applicant and Spouse/Domestic Partner if applicable. The Primary Applicant will automatically be named the beneficiary for Child(ren) named in the application.

Applicant name	Name of beneficiary	Date of birth (MM/DD/YYYY)	Relationship to Applicant	Primary or contingent	Percentage of benefit

Section V. Premium Payment Method

Select one of the following:

☐ Electronic funds transfer (bank draft) *(complete the Electronic Funds Transfer Authorization form)*
Premium mode: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

☐ Direct bill
Premium mode: ☐ Quarterly ☐ Semi-annually ☐ Annually

☐ List bill *(payroll deduction)*
Premium mode: ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ Quarterly ☐ Semi-annually
☐ Annually ☐ 26 Pay ☐ 52 Pay ☐ 10thly ☐ other_____

Group name _____ Group number_____ Is this a Section 125? YES ☐ NO ☐

Section VI. Benefit Selection

Coverage type: ☐ Individual ☐ Individual & Spouse/Domestic Partner ☐ One-parent family ☐ Family

Hospital Indemnity *(all fields must be answered; if the Hospital Admission Benefit is $0, write "0")*:

Plan name _____ 6-day ☐ or 10-day ☐ Hospital Confinement Benefit

Hospital Admission Benefit $_____ Hospital Confinement Benefit amount $_____ Policy modal premium $_____

Optional rider(s) selection *(for an additional premium)***:**

☐ Accident Fixed Indemnity Benefit Rider	Plan name _____	Rider modal premium $_____
☐ Lump Sum Cancer and Recurrence Rider	Benefit amount $_____	Rider modal premium $_____
☐ Lump Sum Heart, Stroke, and Restoration Rider	Benefit amount $_____	Rider modal premium $_____
☐ Specified Disease Benefit Rider	Benefit amount $_____	Rider modal premium $_____

Total policy and optional rider(s) modal premium $_____

☐ Check enclosed *(payable to* **Loyal American Life Insurance Company***)*

☐ Draft bank account for first premium

Section VII. Prior or Other Coverage

	YES	NO
1. Is the Insurance applied for here intended to replace any existing or pending accident or sickness insurance? ..... If YES, please provide the following (and complete the Replacement Notice): Name of company _____ Policy number_____	☐	☐
2. Is any Applicant eligible for Medicare?	☐	☐
3. Is any Applicant applying for Lump Sum Cancer and Recurrence Rider, Lump Sum Heart, Stroke, and Restoration Rider, or Specified Disease Benefit Rider currently covered by any Title XIX program (Medicaid or any similar name)? ..... If YES, any person this applies to is not eligible for Lump Sum Cancer and Recurrence, Lump Sum Heart, Stroke, and Restoration, or Specified Disease Benefit coverage.	☐	☐

Section VIII. Ineligible Occupations *(answer only if applying for the Accident Fixed Indemnity Benefit Rider)*

Are you currently employed in a non-administrative role in one of the industries listed below or are you an active member of the military? Applicant: YES ☐ NO ☐ Spouse/Domestic Partner: YES ☐ NO ☐

- Heavy construction contractors
- Furniture and fixtures
- Fire protection
- Trucking and warehousing
- Primary metal industries
- Lumber and wood products
- Nonmetallic minerals (except fuel)
- Stone, clay, and glass products
- Metal mining
- Bituminous coal and lignite mining

Section IX. Health History Information

Complete the following questions. Please record details of all YES answers below *(attach a separate sheet if needed)*.

If the answer is YES to any question in Part A for any Applicant (person(s) to be covered), that person(s) will be excluded from coverage as applicable.

If the Primary Applicant answers YES to any question in Part A, no one is eligible for coverage.

Part A. *Complete if applying for* **Individual Hospital Indemnity Insurance Policy** — **YES** **NO**

1. Is any Applicant currently unable to perform any of his or her activities of daily living (i.e., mobility, transferring, feeding, dressing, toileting) without human supervision or assistance? ☐ ☐
2. Within the past twelve (12) months, has any Applicant been hospitalized for an inpatient stay, had a nursing home stay, or received home health care due to an injury or sickness (excluding a cold or flu)? ☐ ☐
3. Has any Applicant ever been treated or diagnosed by a medical professional for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for the Human Immunodeficiency Virus (HIV)? ☐ ☐
4. Within the past twelve (12) months, has any Applicant been diagnosed with, treated for, or consulted with a medical professional for:
   a. a heart attack or any disease or disorder of the heart or vascular system, a stroke or Transient Ischemic Attack (TIA), congestive heart failure, heart or heart valve surgery, or bypass surgery? ☐ ☐
   b. cancer, carcinoma in situ, malignant melanoma, or any malignancy except for basal cell or squamous cell skin cancer? ☐ ☐
   c. emphysema, Chronic Obstructive Pulmonary Disease (COPD), lung disorder requiring oxygen, or any other disease or disorder of the lungs (excluding asthma)? ☐ ☐
   d. complications of diabetes, insulin-dependent diabetes (excluding gestational), or any other disease or disorder of the kidneys (excluding kidney stones)? ☐ ☐
   e. hepatitis B or C, cirrhosis, or any other disease or disorder of the liver? ☐ ☐
   f. lupus, neuromuscular disease, Parkinson's disease, Alzheimer's disease, or dementia? ☐ ☐
   g. alcohol or drug abuse or dependency? ☐ ☐
5. Within the past two (2) years, has any Applicant been advised to have any medical test, surgery, or other treatment which has not yet been performed, excluding routine health screenings? ☐ ☐
6. Within the past two (2) years, has any Applicant had an amputation due to disease? ☐ ☐

Question #	Applicant name	Details

Part B. *Complete if applying for* **Lump Sum Cancer and Recurrence Rider**
If the answer is YES to question 7 for any Applicant, the Rider will not be issued. — **YES** **NO**

7. During the past five (5) years, has any Applicant consulted with or been diagnosed, treated, hospitalized, or prescribed medication by a medical professional for, or had symptoms of, cancer, carcinoma in situ, malignant melanoma, or any malignancy except for basal cell or squamous cell skin cancer? ☐ ☐

Part C. *Complete if applying for* **Lump Sum Heart, Stroke, and Restoration Rider**
If the answer is YES to question 9 for any Applicant, the Rider will not be issued. — **YES** **NO**

8. Primary Applicant: Height *(ft.-in.)* _____ Weight *(lbs.)* _____
   Spouse/Domestic Partner: Height *(ft.-in.)* _____ Weight *(lbs.)* _____
9. During the past five (5) years, has any Applicant consulted with a medical professional or been diagnosed, treated, or hospitalized for a heart attack or any disease or disorder of the heart or vascular system, a stroke or Transient Ischemic Attack (TIA), congestive heart failure, heart or heart valve surgery, bypass surgery, high blood pressure requiring three (3) or more medications to control, complications of diabetes, or insulin-dependent diabetes (excluding gestational)? ☐ ☐

Part D. *Complete if applying for* **Specified Disease Benefit Rider**
If the answer is YES to any question in Part D for any Applicant, the Rider will not be issued. — **YES** **NO**

10. During the past five (5) years, has any Applicant had, been diagnosed with, treated for, or taken medication for any of the following: aneurysm, blood clot, pulmonary hypertension, pulmonary fibrosis, tuberculosis, paralysis, or other disorders of the nervous system including Multiple Sclerosis (MS) and Amyotrophic Lateral Sclerosis (ALS)? ☐ ☐
11. Has any Applicant ever been diagnosed with, treated for, or taken medication for kidney disease requiring dialysis? ☐ ☐
12. Has any Applicant ever had an organ transplant or been advised of the need for a transplant? ☐ ☐

Section X. Policyowner's Statements and Agreements

I hereby apply to Loyal American Life Insurance Company (hereinafter "Company" and "Loyal") for insurance coverage to be issued based upon the truth and completeness of the answers to the above questions and understand and agree that: (1) no Agent has the authority to waive the answer to any questions on the application; (2) no insurance will be effective until (a) this signed application has been accepted upon review of the answers I have provided and any medical information reviewed by Loyal, (b) the initial premium has been paid, and (c) a contract has been issued by Loyal American Life Insurance Company; and (3) I have received the Outline of Coverage for the policy applied for, the Replacement Notice form, if applicable, and, if eligible for Medicare, the required *Guide to Health Insurance for People with Medicare*.

I understand that 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 and may be subject to civil and criminal penalties.

The Primary Applicant must sign and date, acknowledging their understanding and agreement to the conditions listed herein. The above statements are true and complete. I understand and agree that for all Applicants these statements shall be the basis for determination of acceptance for coverage under my applicable Loyal policy. I acknowledge and agree that any material misrepresentation or material omission of any Applicant may render this contract null and void from its date of issue in accordance with applicable law. If coverage is revoked, I will receive written notice that will explain the decision and my right to appeal. Loyal will return all paid premiums and fees less any claim payments.

Any Applicant who is applying for the Lump Sum Cancer and Recurrence Rider, Lump Sum Heart, Stroke, and Restoration Rider, or Specified Disease Benefit Rider and is currently covered by Medicaid should not purchase the Lump Sum Cancer and Recurrence, Lump Sum Heart, Stroke, and Restoration, or Specified Disease Benefit coverage.

WAITING PERIOD: The Lump Sum Heart, Stroke, and Restoration Rider has a 30-day Waiting Period which begins on the issue date. No benefits will be paid for any loss that begins during the Waiting Period. WAITING PERIOD means the first 30 days following an Insured Person's issue date.

I understand that the Individual Hospital Indemnity Insurance Policy will not pay benefits for the first 12 months after the issue date for any loss caused by a Pre-Existing Condition which I or any Applicant have had in the past 12 months. PRE-EXISTING CONDITION means any Covered Illness or Covered Injury for which an Insured Person received medical treatment, advice, or services including diagnostic measures, or took prescribed drugs or medicines within 12 months before the Insured Person's most recent effective date of coverage.

I understand that the Lump Sum Cancer and Recurrence Rider or Lump Sum Heart, Stroke, and Restoration Rider will not pay benefits for the first 12 months after the issue date for any loss caused by a Pre-Existing Condition which I or any Applicant have had in the past 6 months. PRE-EXISTING CONDITION means a condition diagnosed or for which medical advice or treatment was recommended by or received from a Physician within the 6 months prior to the issue date.

I understand that the Specified Disease Benefit Rider will not pay benefits for the first 12 months after the issue date for any loss caused by a Pre-Existing Condition which I or any Applicant have had in the past 12 months. PRE-EXISTING CONDITION means a condition diagnosed or for which medical advice or treatment was recommended by or received from a Physician within the 12 months prior to the effective date of the Rider.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Primary Applicant's signature or parent or guardian if Applicant is a minor (Policyowner)	Today's date (MM/DD/YYYY)

Section XI. Agent(s) Certification

I certify that I have provided the Primary Applicant with the following documents:

a. Application packet *(phone sales only)* b. Outline of Coverage c. Other _____

I certify that I have interviewed the Primary Applicant, asked all of the questions as written on the application, and I have truly and accurately recorded on the application the information supplied to me by the Primary Applicant.

Printed name of Licensed Agent	Signature of Licensed Agent	Writing number	Percentage
Printed name of 2nd Licensed Agent		Writing number	Percentage

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

LOYAL AMERICAN LIFE INSURANCE COMPANY® • PO BOX 5725 • SCRANTON, PA 18505-5725

Proposed Insured's Name		**Policy Number (if available)**
Financial Institution Name and Telephone Number		
Financial Institution Address		
9-digit Routing Number	**Account Number**	**Requested Withdrawal Date (1st - 28th)**

Withdraw Payment: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Type of Account: ☐ Personal Checking Account ☐ Personal Savings Account ☐ Corporate/Business Checking

Name of Employer Group _____

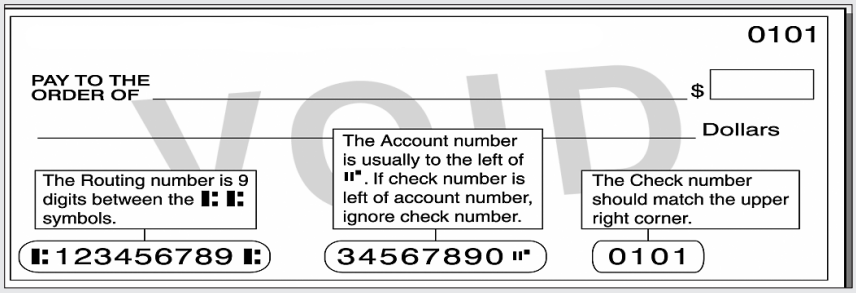
Purpose for submitting this Authorization (check appropriate box(es)):

☐ New authorization ☐ Change in checking/savings account

☐ Change in financial institution ☐ Change in existing coverage

For checking account:
Refer to the sections on the sample check.

For savings account:
Please verify with your bank the account and routing number of your savings account.



APPLICANT INFORMATION FOR FINANCIAL INSTITUTIONS: As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to Loyal American Life Insurance Company provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. I also authorize Loyal American Life Insurance Company and any financial institution it uses to initiate credit entries to my account or to provide refund of premium or association fees (if applicable). I authorize you to accept and to credit these entries to my account. In the event Loyal American Life Insurance Company mistakenly deposits funds into my account, I authorize Loyal American Life Insurance to debit my account for an amount not to exceed the original amount of credit. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

APPLICANT INFORMATION FOR LOYAL AMERICAN LIFE INSURANCE COMPANY: It is understood that the initial draft will occur when the policy is issued. All subsequent drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract and association fees (if applicable), and no other notice of premiums or association fees (if applicable) due will be given. No premium or association fee (if applicable) shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium or association fee (if applicable) payment has been received by Loyal American Life Insurance Company. The cancelled draft will constitute receipt of premium or association fee (if applicable) payment. The privilege of paying premiums and association fees (if applicable) under this Plan may be revoked by Loyal American Life Insurance Company if any draft is not paid upon presentation. The payment of premiums and association fees (if applicable) under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by Loyal American Life Insurance Company upon 30 days written notice.

Name of Payor (if other than Insured) **Payor's Address**

Print name of Depositor (as it appears on account) **Signature of Depositor** **Date**

AUTHORIZATION FORM FOR DISCLOSURE OF AN APPLICANT'S PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of protected health information about me as described below.

1. The Company, as used in this authorization, shall mean American Retirement Life Insurance Company, Loyal American Life Insurance Company®, Cigna Health and Life Insurance Company, Cigna National Health Insurance Company, and their affiliates as described below.
2. I authorize any licensed physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager, or other medical or medically-related facility, the U. S. Veterans Administration and Selective Service System, insurance company, MIB Group, LLC, or any other organization, institution, or person that has any records or information available as to the diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment relating to me or my family to disclose to the Company's underwriting, new business, claims, sales agents, and premium accounting representatives any such records or information. However, MIB Group, LLC, information will only be shared with the Company's underwriting staff and Medical Director.
3. I authorize the Company to make a brief report of my protected health information to MIB Group, LLC.
4. The protected health information described above will be disclosed to the Company to determine my or my family's eligibility to obtain coverage under the policy for which I/we have applied, and to determine the rates and terms which apply to the policy.
5. This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually-transmitted diseases unless otherwise restricted by state law.
6. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Privacy Office at PO Box 5700, Scranton, PA 18505-5700.
7. I understand that the information which will be provided under this authorization is necessary for the Company to determine my eligibility for coverage under the policy and that the Company will condition its approval and issuance of the policy on my providing this authorization, and my application may be denied if I refuse to provide this authorization.
8. I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
9. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this authorization upon request. This authorization will expire twenty-four (24) months from the date it is signed.
10. If you are the representative of an Applicant, describe the scope of your authority to act on the Applicant's behalf:

_____

_____
Applicant's Name

_____
Name of Applicant's Personal Representative, if applicable

_____
Applicant's Social Security Number

_____
Relationship of Personal Representative to the Applicant

_____
Signature of Applicant **Date**

_____
Signature of Personal Representative **Date**

_____
Signature of Company's Agent **Date**

A signed copy of this form will be provided with the policy if issued and any other time upon request.

AUTHORIZATION FORM FOR DISCLOSURE OF A CONSUMER'S PROTECTED HEALTH INFORMATION FOR MARKETING PURPOSES ("Authorization")

1. I hereby authorize the use and disclosure of all my health information, including but not limited to my personal and medical information contained in the Company's records ("Protected Health Information") to American Retirement Life Insurance Company, Loyal American Life Insurance Company®, Cigna Health and Life Insurance Company, Cigna National Health Insurance Company, and their affiliates ("Company") as described below.
2. I authorize the Company to use the Protected Health Information contained in the Company's records, including its underwriting and claim records, to help determine whether I might be interested in or can benefit from other non-health-related insurance products offered by the Company.
3. I understand that the Company will disclose the Protected Health Information to its underwriting staff, new business staff, sales agents, or marketing management for the purpose of marketing non-health-related products to me.
4. I understand that I may revoke this Authorization at any time, except to the extent that action has been taken by the Company in reliance on this Authorization, by sending a written revocation to the Company's Privacy Steward at PO Box 5700, Scranton, PA 18505-5700.
5. I understand that the Protected Health Information which the Company will use and disclose under this Authorization is not necessary for the Company to determine my eligibility for coverage under the policy and that the Company will not condition its approval and issuance of the policy on my providing this Authorization.
6. I understand that if the person or entity that receives my Protected Health Information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
7. I understand that a photocopy, facsimile copy, or other electronic copy of this Authorization is as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this Authorization. This Authorization will remain in effect for two (2) years from the day my policy(ies) is terminated or the day I revoke my permission.
8. By providing my telephone number(s) on the attached application for insurance, I consent to receive calls, texts, or autodialed or prerecorded telemarketing messages from Cigna and its affiliates.

If you are the representative of a Consumer, describe the scope of your authority to act on the Consumer's behalf:

_____

_____ _____

Consumer's Name **Name of Consumer's Personal Representative, if applicable**

_____ _____

Signature of Consumer **Date** **Relationship of Personal Representative to the Consumer**

_____ _____

Signature of Company's Agent **Date** **Signature of Personal Representative** **Date**

A signed copy of this form will be provided to you.

Loyal American Life Insurance Company®
PO Box 5725, Scranton, PA 18505-5725 • Toll Free: 866-459-4272

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application and information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Loyal American Life Insurance Company®. Your new policy provides 30 days in which you may decide, without cost, whether or not you decide to keep this policy. 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 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 any 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