Application

Protection Series℠–

Hospital Indemnity Flex Insurance Plan

Policy Form CLHIPL117FL or CLHIPL217FL

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

Florida

AetnaSeniorProducts.com

Continental Life Insurance Company of Brentwood, Tennessee
An Aetna Company

P.O. Box 14399
Lexington, KY 40512-9700

Application for Hospital Indemnity Flex Insurance Plan

from Continental Life Insurance Company of Brentwood, Tennessee

- Print clearly and use blue or black ink.
- Complete all required sections of the application. Any incomplete or missing information could delay processing of your application.

Please select one: ◯ New business
◯ Reinstatement *Policy number* .....

1. Proposed insured information

Go paperless! To receive your policy documents online, select "electronically" and provide your current e-mail address in Section 1. You will not receive paper policy documents, but instead, will receive an e-mail with a link to access them on our secure website.

Policy delivery
(For agent use only; select one):
Agent: ◯ Mail
Applicant: ◯ Mail ◯ Electronically

Full name of proposed insured *First, M.I., Last*
.....

Residential address ..... Phone .....

City ..... State ..... Zip .....

Mailing address ..... Phone .....

City ..... State ..... Zip .....

E-mail ..... Social Security number .....

Birth date *mm/dd/yyyy* ..... Age ..... ◯ Male ◯ Female

2. Benefits information

Requested Effective Date: .....

Base benefit selected *(select only one)* — **Benefit amount** — **Premium amount**

◯ **Option 1. Hospital admission indemnity:** $..... $.....
Policy form CLHIPL117 FL
$250 units $250-$4,000

Daily hospital indemnity $ 15 $.....
Policy form CLHIPL117 FL
$15 per day for 31 days

◯ **Option 2. Daily hospital indemnity:** $ 15 $.....
Policy form CLHIPL217 FL
$15 per day for 31 days

Additional coverage $..... $.....
Covered days: *(select only one)* ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10 ◯20
Policy form CLHIPL217 FL
$10 units up to maximum $1,000
50% benefit for observation stays less than 24 hours in an observation unit
Please see rate table for minimum number of units (depends on covered days).

Optional benefit riders:

◯ **Daily skilled nursing facility:** $..... $.....
Covered days: *(select only one)* ◯ Days 1-20 ◯ Days 21-100 ◯ Days 1-100
Rider form CLIHIPRID217 FL
$10 units up to maximum $500

2. Benefits information *continued*

Optional benefit riders: *continued*	**Benefit amount**	**Premium amount**
○ **Doctor visit indemnity:** Rider form CLIHIPRID417 FL $10 units up to maximum $100	$.....	$.....
○ **Outpatient surgical procedure:** Rider form CLIHIPRID517 FL $250 units up to maximum of $3,000	$.....	$.....
○ **Ambulance and ER:** Rider form CLIHIPRID317 FL	○ $200 per event ○ $400 per event ○ $600 per event	$.....
○ **Outpatient rehabilitation services:** Covered days: *(select only one)* Rider form CLIHIPRID817 FL $50 units up to a maximum of $250 per visit	○ 15 days ○ 30 days ○ $50 units ○ $200 units ○ $100 units ○ $250 units ○ $150 units	$.....
○ **Lump sum cancer:** Benefit amounts: *(select only one)* Rider form CLIHIPRID117 FL	○ $2,500 ○ $15,000 ○ $5,000 ○ $20,000 ○ $10,000	$..... **Total premium** $.....

*In this example, coverage would begin on the 21st day of your covered Skilled Nursing Facility stay. Benefits would end on day 100 (if still confined).

Example:

Base Benefit 1: Hospital admission benefit: 10 units x $250=$2,500

Hospital admission benefit: $2,500

Daily Hospital Indemnity: $15 per day for 31 days

Optional Riders:

Daily skilled nursing facility benefit: 10 units x $10=$100 daily benefit
Covered days: Days 21-100*

Doctor visit indemnity: 3 units x $10=$30

Outpatient surgery: 4 units x $250=$1,000

Initial premium:

○ Draft initial premium upon policy approval ○ Draft initial premium on policy effective date

Premium mode:

○ Annual ○ Semi-annual ○ Quarterly ○ Monthly bank draft *(electronic funds transfer)*

Payment method:

○ Check ○ Electronic funds transfer ○ List Bill billing file identifier .....

Premium collected:

$ .....

PAYMENT MODES

You have a choice among several payment options or modes for paying your premium (annual, semi-annual, quarterly and monthly bank draft). Each payment mode, other than annual and monthly bank draft, results in higher total yearly premium costs. Reasons for higher costs include added collection and administrative costs, time value of money considerations and lapse rates.

The annual and monthly bank draft modes have the same total yearly premium costs. As a result, there is a time value of money advantage to you for paying monthly versus annually. However, there may be other advantages to you for choosing an annual payment based on your preferences. Your agent can explain the differences in modes and help you decide which is best for you. You have the right to change your payment mode, among the modes available, during the life of your policy.

3. Health questions

If you are in the age range of 64½ through 67 on the date you sign this application, skip questions 1-9.

Note: Pre-existing condition limitations apply regardless of whether or not you are required to answer the health questions.

If any answer to questions 1-9 in Section 3 is "yes," the application will be declined.

1. Are you currently:		
A. confined to a hospital or nursing facility?	○ Y	○ N
B. receiving any type of home health care?	○ Y	○ N
C. dependent on a wheelchair or motorized mobility device?	○ Y	○ N
D. bedridden?	○ Y	○ N
2. Within the past 36 months have you been diagnosed or treated by a medical professional or had surgery for any of the following:		
A. congestive heart failure, CVA, stroke, kidney disease, Cirrhosis, Paget's disease, lupus or any connective tissue disorder?	○ Y	○ N
B. internal cancer (including breast cancer and prostate cancer), leukemia, lymphoma or melanoma?	○ Y	○ N
C. Alzheimer's disease, dementia, Parkinson's disease, cerebral palsy, multiple sclerosis, epilepsy, or any other neurological or neuromuscular disorder?	○ Y	○ N
D. tested positive for exposure to the human immunodeficiency virus (HIV) infection or been diagnosed as having AIDS related complex (ARC) or acquired immune deficiency syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?	○ Y	○ N
3. Within the past 24 months have you:		
A. been prescribed the use of oxygen by a licensed medical professional?	○ Y	○ N
B. received medical treatment by a licensed medical professional for an open colostomy or ileostomy?	○ Y	○ N
C. been diagnosed or treated by a licensed medical professional for any type of amputation caused by disease?	○ Y	○ N
D. been diagnosed or treated by a licensed medical professional for osteoporosis with compression fracture?	○ Y	○ N
E. been diagnosed or treated by a licensed medical professional for transient ischemic attack (TIA)?	○ Y	○ N
F. been recommended by a licensed medical professional to be hospitalized?	○ Y	○ N
4. Do you have insulin dependent diabetes in conjunction with a heart disorder (other than high blood pressure) that has been diagnosed by a licensed medical professional?	○ Y	○ N
5. Within the past 12 months have you been diagnosed or treated by a medical professional or had surgery for any of the following:		
A. heart attack?	○ Y	○ N
B. artery disease, including peripheral vascular disease (PVD) and peripheral artery disease (PAD)?	○ Y	○ N
C. any blood disorder?	○ Y	○ N
D. chronic respiratory disorder, hepatitis, pancreatitis, chronic cystitis, ulcerative colitis?	○ Y	○ N
E. mental or nervous disorder?	○ Y	○ N
6. Do you have diabetes:		
A. that requires the use of 40 or more units of insulin?	○ Y	○ N
B. with any complications resulting from the diabetes?	○ Y	○ N
7. Are you currently taking or been advised by a medical professional to take 4 or more prescription drugs for heart or artery disease, or heart rhythm disorders?	○ Y	○ N
8. Within the last 12 months have you been advised by a medical professional:		
A. to have any testing, surgery, or other evaluation and not done so, or have test results pending?	○ Y	○ N
B. that surgery may be required within the next year for any existing health condition, including cataracts or joint replacement?	○ Y	○ N
9. Within the past 12 months, have you been advised by a licensed medical professional to have treatment or counseling for alcool or drug abuse?	○ Y	○ N

3. Health questions *continued*

Answer question 10 if you have selected the Lump Sum Cancer Benefit. If the answer to question 10 is "yes" the Lump Sum Cancer benefit will not be added.

10. Within the past 10 years, have you:

A. been tested to determine if cancer is present where the results are pending the test results indicated further treatment or evaluation is needed? ○ Y ○ N

B. been diagnosed with or treated for or are currently seeking treatment by a medical professional including surgery, radiation or chemotherapy for leukemia, Hodgkin's Disease, lymphoma, melanoma, sarcoma, myeloma, or any internal cancer? ○ Y ○ N

4. Physician information

Your primary physician Phone

Physician's office name

City State

Specialist seen in the past 24 months Specialty

Reason for seeing (diagnosis)

Date of first visit Date of last visit

Specialist seen in the past 24 months Specialty

Reason for seeing (diagnosis)

Date of first visit Date of last visit

If additional space is needed, please use a separate sheet of paper and attach to the application.

Have you seen any additional physicians other than those listed above in the past 24 months? ○ Y ○ N

5. Prescribed medications

If additional space is needed, please use a separate sheet of paper and attach to the application.

Prescribed medications	**Reason for medications (diagnosis)**

6. Replacement questions

Do you have any other health insurance in force? ○ Yes ○ No

Type of coverage Policy number Company

Type of coverage Policy number Company

Is the policy being applied for intended to replace any other insurance? ○ Yes ○ No

Type of coverage Policy number Company

7. Account information

Complete this section if you are requesting electronic funds transfer (EFT) for premium payment.

Include a voided check with the application.

Draft date cannot be on the 29th, 30th or 31st of the month. Requesting to have a draft date more than 15 days greater than the policy's paid to date will draft a month in advance.

Proposed insured's name

▪

Account owner name, if different than proposed insured's

▪

Account owner relationship to proposed insured:

◯ Business owned by proposed insured ◯ Living trust ◯ Employer

◯ Power of attorney ◯ Conservator/guardian

◯ Family member; specify ▪

Financial institution name

▪

◯ Checking ◯ Savings

Routing number

▪

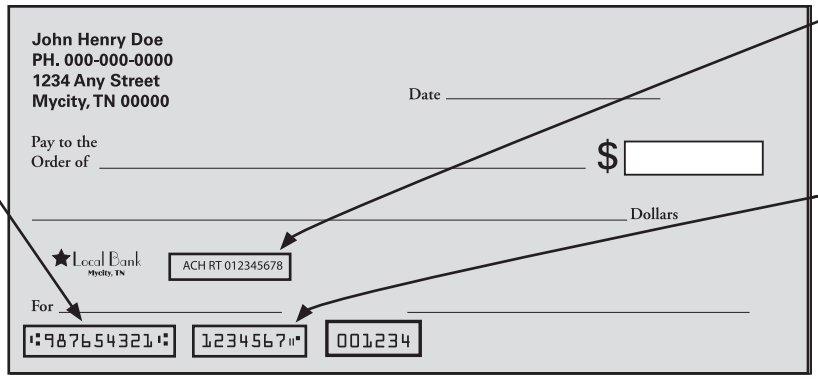
Account number

▪

Requested EFT draft date for ongoing premium payments *(if different from initial premium draft date)*

▪

This is an example of a personal check. A business check may be different.



For all other checks, use the nine-character bank **routing number**, which appears between the ⑆ symbols, usually at the bottom left corner of the check.

For checks with an **ACH RT (Automated Clearing House Routing) number**, please use this number.

The **account number** is up to 17 characters long and appears next to the ⑈ symbol at the bottom of the check and usually to the right of the bank routing number.

8. Electronic funds transfer (EFT) authorization

I understand and accept these terms and conditions:

- We are authorized to withdraw funds periodically from your account to pay insurance premiums for the insured.
- If your financial institution does not honor an EFT request, we will NOT consider your premium paid.
- If your financial institution does not honor an EFT request, we may make a second attempt within five business days.
- We have the right to end EFT payments at any time and bill you directly either quarterly or less frequently for premiums due.
- Information as to each EFT charge will be provided by entry on your account statement or by any other means provided by your financial institution. You will not receive premium notices from us.
- If you want to cancel or change this authorization, you must contact us at least three business days before a scheduled withdrawal.
- Any refund of unearned premium will be made to the policy owner or the policy owner's estate.

Signature only required if the account owner is different than the proposed insured.

Signature of account owner

X ▪

Date

▪

9. Applicant

I hereby apply to Continental Life Insurance Company of Brentwood, Tennessee for a policy to be issued in reliance on my written answers to the questions on this application. I have read or had read to me the completed application and understand all statements and answers and certify that to the best of my knowledge and belief, they are true, complete and correctly recorded. I acknowledge that I have received an outline of coverage for the policy applied for, and if 65 years of age or older, *A Guide to Health Insurance for People with Medicare* and a Non-Duplication of Medicare Disclosure.

I agree (1) this application and any policy issued will constitute the entire contract of insurance and the Company will not be bound in any way by any statements, promises or information made or given by or to any agent or other person at any time unless the same is in writing and submitted to the Company at its Home Office and made a part of such contract. Only a Company Officer can make, modify or discharge contracts or waive any of the Company's rights or requirements and then only in writing; and (2) this insurance will not become effective until the application is approved by the Company, the first premium is paid, during which there has been no change in my health condition as stated on the application and a policy has been issued by the Company.

I understand and agree that, if I choose to pay my premium by electronic funds transfer (EFT) from my checking or savings account, I am accepting the terms and conditions of the EFT authorization attached to this application.

I understand that if any answers on this application are incorrect, incomplete or untrue, Continental Life Insurance Company of Brentwood, Tennessee may adjust my premium, reduce my benefits or rescind the policy.

I understand that this policy provides supplemental health insurance.

Applicant signature	Date signed
X	.

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.

10. Privacy notice

Although your application is our initial source of information, we may collect information including health history and medical records from persons other than you, and we may conduct a telephone interview with you. Continental Life Insurance Company of Brentwood, Tennessee, its affiliates, or its reinsurer(s) may also in certain circumstances release information collected by us to third parties with authorization from you for a period of 24 months. Upon written request, we will provide you with the information contained in your file. Medical information will be disclosed to you only through the medical professional you designate. Should you wish to request correction, amendment or deletion of any information in your file, which you believe inaccurate, please contact us and we will advise you of the necessary procedures.

I understand that I may revoke the authorization of health information at any time by notifying the Company in writing at their Administrative Office: 800 Crescent Centre Dr., Suite 200, Franklin, TN 37067. I understand that such revocation will not have any effect on actions taken by the Company prior to their receiving the revocation notice.

I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under a policy. A photocopy of this authorization will be treated in the same manner as the original.

11. Producer compensation

When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our Companies, or for the percentage of completed sales. Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

12. Agent

All information **must** be completed.

I certify that:

1. I have accurately recorded the information supplied by the applicant.
2. The application was provided to the applicant to review or was read to them and the applicant has been advised that any false statement or misrepresentation in the application may result in an adjustment of premium, reduction of benefits or rescission of the policy.
3. I have provided an outline of coverage for the policy applied for, and if 65 years of age or older, *A Guide to Health Insurance for People with Medicare* and a Non-Duplication of Medicare Disclosure to applicant prior to completing the application.

The writing number reflects where commissions will be paid.

Agent name *Printed*	Writing number (agent or company)
.	.
Agent signature	State license ID number (for FL only)
X	.
Phone	E-mail
.	.

13. Agent request to split commissions

This section must be completed with this application in order to split commissions.

If this application results in an issued policy through Continental Life Insurance Company of Brentwood, Tennessee (CLI), the agents listed below have agreed to split the commissions earned on the policy.

- Both agents must be properly licensed and appointed with CLI in the policy's state of issue.
- Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains inforce.
- The percentage of the premium split can be for any amount but must be stated in whole numbers and total 100%. (For example, the percentage for the premium split can be from 1% to 99% but cannot be 0% or 100%.)
- Calculation of each agent's commissions are based on their respective CLI commission schedule.

Agent Information *Print*

Writing agent		Percentage
.		. %
Secondary agent	**Writing number**	**Percentage**
.	.	. %

By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.

Writing agent signature

X

14. Fraud warnings

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

Arkansas and Louisiana and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in 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 the 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 a 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: 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 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.

Maine and Tennessee and 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 may include imprisonment, fines or a denial of insurance benefits.

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

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or a deceptive statement is guilty of insurance fraud.

Oklahoma: 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.

Continental Life Insurance Company of Brentwood, Tennessee
An Aetna Company

P.O. Box 14399
Lexington, KY 40512-9700

800-264-4000
AetnaSeniorProducts.com
office hours 7:00 a.m. - 7:00 p.m. CST

Initial premium receipt

from Continental Life Insurance Company of Brentwood, Tennessee

- Print clearly and use blue or black ink.
- Applicant keeps this receipt for their records.
- Be sure that all required sections of the application are completed. Any incomplete or missing information could delay processing of your application.

Initial premium receipt

Applicant name *Printed*

Date of application *mm/dd/yyyy*

Electronic funds transfer (EFT) draft amount
$

Initial modal premium collected/drafted
$

Electronic funds transfer (EFT) draft date

This acknowledges receipt of the initial premium in connection with your application for a Continental Life Insurance Company of Brentwood, Tennessee Hospital Indemnity Flex insurance policy.

Agent name *Printed*

Phone

Signature of agent

X

- Payment will be refunded for any coverage not issued.
- A recorded telephone interview may be necessary as part of the underwriting on your application for insurance.
- All premium payments must be made payable to Continental Life Insurance Company of Brentwood, Tennessee.
- DO NOT make any check payable to the agent and do not leave the payee blank on the check.

A. If this payment equals the full, initial premium for the mode of premium payment selected by the applicant(s); and B. if the answers are true and correct in the application and if Continental Life Insurance Company of Brentwood, Tennessee issues a policy according to its rules, limits, and standards for the plan and amount applied for by the applicant(s); then this payment shall be applied to the payment of the first premium of the issued policy. No policy shall be effective until it has actually been issued by Continental Life Insurance Company of Brentwood, Tennessee.

Thank you for choosing
Continental Life Insurance Company of Brentwood, Tennessee!