Loyal American Life Insurance Company®

P.O. Box 559004 ·Austin, Texas 78755-9004 · Toll Free Phone Number: 1-800-633-6752

APPLICATION FOR ACCIDENT EXPENSE INSURANCE POLICY FORM L-5350-PA

Applicant (First, M.I., Last)		S.S. Number	
☐ Male ☐ Female	Age	Birthdate	Home Phone Number
Home Address	City	State	Zip
Height	Weight	Job/Title Occupation	Duties
☐ Payor or ☐ Owner (if other than Applicant) & Address		S. S. Number and Tax ID Number	Birthdate
Primary Beneficiary: Full Name - Age - Relationship		Contingent Beneficiary: Full Name - Age - Relationship	

DEPENDENTS PROPOSED FOR COVERAGE

	Full Name	Sex	Birthdate	Height	Weight
Spouse		M ☐ F ☐			
Children		M ☐ F ☐		**X**	**X**
		M ☐ F ☐		**X**	**X**
		M ☐ F ☐		**X**	**X**
		M ☐ F☐		**X**	**X**

Billing Mode ☐ Monthly Bank Draft ☐ Monthly List Bill ☐ Quarterly ☐Semi Annual ☐ Annual

BENEFITS

Coverage	Applicant	Spouse	Child(ren)	Modal Premium
Accident Expense Policy Maximum Benefit Amount Annual Deductible ($0, $100, $150, $200)	$_______ per year $_______ per year	$_______ per year Same as Applicant	$_______ per year Same as Applicant	
Hospital Admission Rider Maximum Benefit Amount	$_______ per year	$_______ per year	$_______ per year	
Hospital Daily Room Benefit Rider Maximum Benefit Amount Maximum Benefit Period (30 or 60 days) Elimination Period (0, 1, or 2 days)	$________ per day _________ days _________ days	$________ per day Same as Applicant Same as Applicant	$________ per day Same as Applicant Same as Applicant	
Hospital Intensive Care Rider Maximum Benefit Amount	$________ per day	$________ per day	$________ per day	
Outpatient Surgery Rider Maximum Surgery Benefit	$_______ per year	$_______ per year	$_______ per year	
Critical Illness First Occurrence Benefit Rider	$_____________	$_____________	$_____________	
Heart Attack & Stroke First Occurrence Benefit Rider*	$_____________	$_____________	$_____________	
Cancer First Occurrence Benefit Rider*	$_____________	$_____________	$_____________	
Accidental Death & Dismemberment Benefit Rider	$_____________	$_____________	$_____________	
TOTAL PREMIUM				

*** If you select the Critical Illness First Occurrence Rider you may not select the Cancer First Occurrence Rider or the Heart Attack & Stroke First Occurrence Rider.**

MEDICAL QUESTIONNAIRE

If any of the QUESTIONS in # 1 thru #11 are answered "YES", PLEASE LIST the REQUIRED HEALTH HISTORY in # 13.

All Applications	1. Has any applicant been diagnosed by or received treatment from a member of the medical profession for an immune deficiency disorder, AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or tested positive on a Human Immunodeficiency Virus (HIV) test? 2. Has any adult applicant not been actively at work on a full-time basis, at least 20 hours per week; not been able to perform the material and substantial duties of their occupation; and missed work, or not been able to work due to illness or injury (except for minor illness or injury of 1 week or less, or normal pregnancy), for at least 120 days?	☐ Yes ☐ No ☐ Yes ☐ No
Hospital Benefits	3. Within the past 10 years, has any applicant been medically diagnosed as having or been medically treated for cancer in any form? 4. Has any applicant been charged with driving under the influence (DUI) of drugs or alcohol within the last ten years? If YES, provide date and driver's license number. ____ 5. Within the past 5 years, has any applicant been medically diagnosed as having, or been medically advised to have, treatment for high blood pressure, heart disease/disorder, stroke, lung or respiratory disorder, diabetes, kidney or liver disease, emotional or nervous system disorder, or birth defects? 6. Within the past 5 years, has any applicant had, or been advised by a medical professional to have, any medical treatment? 7. Are you or any person to be insured under this benefit currently pregnant? If YES, who? ______________ If YES, any individual named will be excluded from coverage.	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Cancer, Heart Attack & Stroke, Critical Illness Benefits	8. Has any applicant been medically diagnosed as having or been medically treated for cancer in any form? 9. Has any applicant been medically advised to have tests to determine if cancer is present? 10. Does any applicant now have, or have they ever been medically diagnosed as having, Multiple Sclerosis, Renal Failure or Muscular Dystrophy? 11. Does any applicant now have, or have they ever been medically diagnosed as having, a heart condition, heart attack, stroke, cerebral vascular accident or any other problem of the circulatory system?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Accidental Death	12. Has any person to be insured engaged in or intend to fly, race, skin or scuba dive or hang–glide?	☐ Yes ☐ No
Health History	13. Name / Nature of Incident / Date & Duration / Name & Address for Doctor or Hospital/Clinic ______________________________ ______________________________ ______________________________ ______________________________ ______________________________ ______________________________	

NON-MEDICAL QUESTIONNAIRE

All Applications	1. Is any applicant eligible for Medicare? 2. **Existing Insurance**. Is there any other cancer, critical illness, accident, or hospital indemnity insurance in force or applied for on any applicant? If YES, list name, company and policy number, year issued, type of coverage, and amount of benefit. ______________________________ ______________________________ 3. **Replacement**. Is the insurance applied for to replace or change any existing health, or accident coverage? If YES, complete the replacement form(s) provided by your agent and return with this application. 4. I have received an Outline of Coverage, for each policy applied for.	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

AGREEMENT: I have read or had read to me the completed application and any supplement, and my statements and answers are true and complete. I understand that any material misstatement or misrepresentation in the application may result in loss of coverage. I understand that the effective date of the policy will be the date stated on the policy's schedule page, not the date this application is signed. I understand that no agent can accept risks, modify policies, or waive any rights or requirements of Loyal American. I acknowledge that I have received notices about the Medical Information Bureau, and the Fair Credit Reporting Act.

MEDICAL AUTHORIZATION: I authorize the Medical Information Bureau and any insurance company, licensed physician, medical practitioner, hospital, clinic, or other medical related facility, that has any record of my health, to give Loyal American Life Insurance Company, any of its reinsurers, its authorized agent or underwriters any medical information requested for the purpose of determining the eligibility of the person proposed for coverage. A photocopy of this authorization shall be as valid as the original. This authorization shall be valid for thirty months. I understand that either myself or my authorized representative is entitled to receive a copy of this authorization form.

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.

ANY MATTER IS DISPUTE BETWEEN YOU AND THE COMPANY MAY BE SUBJECT TO ARBITRATION AS AN ALTERNATIVE TO COURT ACTION PURSUANT TO THE RULES OF THE AMERICAN ARBITRATION ASSOCIATION. ANY DECISION REACHED BY ARBITRATION SHALL BE NONBINDING AND APPEALABLE TO A COURT OF PROPER JURISDICTION.

Signed at ____ this ______ day of ____
(city) (state) (month) (year)

Signature of Applicant X____

Signature of Other Insured (if applicable) X____

Affidavit for Agent's Use Only: I hereby certify that I have accurately recorded in this application all information supplied by the applicant. The applicant has read or had read to him or her the completed application. I also certify that this insurance does ☐ does not ☐ replace or change any existing accident or health coverage

Writing Agent's Signature ____ **Agent's No.** ________________________

Agent's Name: (please print) ____

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO "Loyal American Life Insurance Company"

DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

LOYAL AMERICAN LIFE INSURANCE COMPANY℠

THIS FORM MUST BE COMPLETELY FILLED OUT TO BE ACCEPTED

Proposed Insured's Name	Policy Number (Home Office Only)

If the account to be drafted is a Dedicated (Checking or Savings) or Savings account, fill in the shaded boxes.
If this is a Personal/Business Checking Account you must attach a voided check for processing. Staple voided checks on the box below.

SEG Name (Selected Employer Group) if applicable:	
Name of Financial Institution:	
Address & Phone Number of Financial Institution:	
Transit No. & Routing	Savings or Dedicated Account No.

Bank account is (Check appropriate box)

- ☐ Personal checking account
- ☐ Personal savings account
- ☐ Corporate/Business checking account
- ☐ Dedicated Draft Checking account
- ☐ Dedicated Share Savings account

Purpose for submitting this authorization (Check appropriate box/boxes):

- ☐ **New pre-authorized payment plan**
- ☐ Change in checking account
- ☐ Change in savings account
- ☐ Change in the Dedicated account noted above
- ☐ Change in bank
- ☐ Addition of new policy to plan
- ☐ Change in existing coverage

Desired date for withdrawal from checking/savings account. (Any date between the 1st and 28th of each month):__________

TOTAL AMOUNT OF PAYMENT FOR THIS POLICY $______________________

Withdraw My Payment:__________Monthly__________Quarterly__________Semi-Annually__________ Annually

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. 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 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 no other notice of premiums due will be given. No premium shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium payment has been received by Loyal American. The cancelled draft will constitute receipt of premium payment. The privilege of paying premiums under this Plan may be revoked by Loyal American if any draft is not not paid upon presentation. The payment of premiums under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by Loyal American upon 30 days written notice.

Print name as it appears on account	Date
Signature of depositor	