All Shaded areas must be completed.

APPLICATION FOR CANCER INSURANCE - PART 1

Life Insurance Company of Alabama

P. O. Box 349 · Gadsden, Alabama 35902

Please Use Dark Ink Suitable for Photocopying.

Do you have a current Medicaid eligibility card or other state sponsored insurance program? ■ Yes ■ No

1. PROPOSED INSURED ☐Married ☐Divorced ☐Widowed ☐Single ☐Separated LAST NAME FIRST M.I.	BIRTHDATE MO	DAY	YR	AGE	SEX	SOCIAL SECURITY #
SPOUSE						
DEPENDENT CHILDREN PROPOSED for INSURANCE						

2. RESIDENCE ADDRESS STREET	CITY	COUNTY	STATE	ZIP	PHONE: RES: ( ) BUS: ( ) E-MAIL:

3. INSURED'S EMPLOYER	EMPLOYMENT DATE

CANCER INDEMNITY INSURANCE BASE PLAN - C75 *Answer questions 4 - 9*

☐ Individual ☐ Individual/Spouse ☐ 1 Parent Family ☐ 2 Parent Family

Daily Hospital Indemnity Benefit ☐ $300 ☐ $200 ☐ $100

PREMIUM

INCLUDED RIDERS

Radiation & Chemotherapy Rider ☐ $2,000 ☐ $1,000 ☐ $500

Cancer Screening Wellness Benefit & Diagnostic Testing Indemnity Rider ☐ $100 ☐ $50

Surgical Benefits Rider $6,500

Transportation Rider

Stem Cell or Bone Marrow Transplant Rider $10,000

$_____ Cancer Plan with Included Riders

OPTIONAL RIDERS

First Occurrence Cancer Lump Sum Limited Rider ☐ $5,000 ☐ $2,500 ☐ $1,250
☐ Individual ☐ Individual/Spouse ☐ 1 Parent Family ☐ 2 Parent Family

$_____ First Occurrence Lump Sum Benefit Rider

First Occurrence Building Benefit Rider ☐ $5,000 ☐ $2,500 ☐ $1,250
☐ Individual ☐ Individual/Spouse ☐ 1 Parent Family ☐ 2 Parent Family

$_____ First Occurrence Building Benefit Rider

Specified Disease Rider *Answer question 11*
☐ Individual ☐ Individual/Spouse ☐ 1 Parent Family ☐ 2 Parent Family

$_____ Specified Disease Rider

Hospital Intensive Care Rider ☐ $300 ☐ $450 ☐ $600 ☐ $____ *Answer question 10*
☐ Individual ☐ Individual/Spouse ☐ 1 Parent Family ☐ 2 Parent Family

$_____ Hospital Intensive Care Rider

TOTAL $_____

4. PREMIUM MODE & METHOD: Monthly Direct Bill **Not** Available

☐ Annual ☐ Semi Annual ☐ Quarterly ☐ Monthly

☐ Bank Draft ☐ Payroll Deduction ☐ Direct Bill ☐ Family Bill

5. Will the policy applied for replace any insurance in force on any proposed covered person? ☐YES ☐NO

6. If yes, state name of company.

Company *Year Issued*

7. Primary Beneficiary & Relationship

8. Contingent Beneficiary & Relationship

HOME OFFICE USE:

9. CANCER INDEMNITY INSURANCE

9a. Has any person proposed for coverage under this Policy ever tested positive, been diagnosed as having or been treated for acquired immune deficiency syndrome (AIDS), or Human Immunodeficiency Virus (HIV) in any form? ☐YES ☐NO

9b. Has any person proposed for coverage under this Policy within the last 24 months, had any elevated or rising PSA or CEA test or abnormal mammogram, pap smear, radiological exam (e.g. X-Ray, MRI, CAT Scan, sonogram, ultrasound, echo tests, etc.), biopsy or scope procedure (e.g. colonoscopy, endoscopy, etc.) or are awaiting further tests or test results? ☐YES ☐NO

9c. Has any person proposed for coverage under this Policy **within the last five years**, been diagnosed as having or been treated for any cancer, including skin cancer, Hodgkin's Disease and Leukemia, in any form? ☐YES ☐NO

9d. Has any person proposed for coverage under this Policy been diagnosed, as having or been treated for any cancer, including skin cancer, Hodgkin's Disease and Leukemia, in any form **within the last ten years?** ☐YES ☐NO

If yes to question 9 a, b or c, any person(s) so designated will not be covered under the policy.

If yes to question 9d, you are eligible for a policy that provides Option C Radiation & Chemotherapy Benefits and $100 per day Daily Room Benefit for the treatment of cancer. No additional amounts will be issued.

APPLICATION FOR CANCER INSURANCE - PART 2

10. INTENSIVE CARE:
In the last ten years has any proposed insured been diagnosed or treated for Heart Disease, Heart Attack, Any Heart Condition, Heart Trouble or Any Abnormality of the Heart, Acquired Immune Deficiency Syndrome (AIDS), Aids Related Complex (ARC) or Human Immunodeficiency Virus (HIV)? ☐YES ☐NO

10a. If this is a Two Parent Family Policy/Rider, is any person to be insured currently pregnant or taking fertility drugs? ☐YES ☐NO

10b. If this is a One Parent Family Policy/Rider, are you, your fiancee or companion currently pregnant or taking fertility drugs? ☐YES ☐NO

If yes to question 10a or 10b, we will issue an individual policy/rider on the adult male family member only.

11. SPECIFIED DISEASE:
No one proposed for coverage under this Policy has in the last 10 years had treatment or diagnosis of: • Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease) • Botulism • Bubonic Plague • Cerebral Palsy • Cholera • Cystic Fibrosis • Diphtheria • Encephalitis (including encephalitis contracted from West Nile virus) • Huntington's Chorea • Lyme Disease • Malaria • Menningitis (Bacterial) • Multiple Sclerosis • Muscular Dystrophy • Myasthenia Gravis • Necrotizing Fasciitis • Osteomyelitis • Polio • Rabies • Reye's Syndrome • Rheumatic Fever • Rocky Mountain Spotted Fever • Scleroderma • Sickle Cell Anemia • Smallpox • Systemic Lupus • Tetanus • Toxic Shock Syndrome • Tuberculosis • Tularemia • Typhoid Fever • Variant Creutzfeldt-Jakob Disease (Mad Cow Disease)• Yellow Fever? ☐YES ☐NO

DETAILS of questions 5-11 answered "yes" including question number, names and addresses of physicians and individuals to whom history pertains.

As normal procedure, the Home Office Underwriting Department may contact you by telephone to verify pertinent information contained in your application. What is the best way to reach you?

Home/Office Phone:

Cell Phone:

Email address:

CERTIFICATION- The Applicant hereby makes application to Life Insurance Company of Alabama for a policy or policies of insurance and represents that the statements and answers set forth under Parts 1 and 2 of this application by whomsoever written, are full, complete and true to the best of Applicant's knowledge and belief and agrees that they shall be considered as the basis of any insurance which may be issued hereon. The undersigned applicant and agent acknowledge that the applicant has read, or had read to him/her, the completed application and that he/she realizes that policy issuance is based upon statements and answers provided herein. I further understand that the policy and rider(s) is not effective until the effective date specified in the policy and that the policy applied for will not pay benefits for any claims which occur prior to the effective date of the policy.

Important Notice: You should have comprehensive health coverage before purchasing this type of policy.

I, the agent, hereby certify by my signature below that, I have truly and accurately recorded on this application the information supplied by the applicant.

X _____ #77007
Agent Agent's No.

George E Daniel Jr

X _____
Agent Agent's No.

AGENT'S STATEMENT: To the best of your knowledge does this insurance replace any existing insurance? ☐ Yes ☐ No
If Yes, give name of company and policy number.

Signed at _____
City State

Date _____
Month Day Year

X _____
Signature of Proposed Primary Insured

Form AHC7509GA