

## AUTHORIZATION TO MY BANK

### PREAUTHORIZED CHECK AUTHORIZATION

**Attach Voided Check or Deposit Ticket Here  
and Sign Authorization**

Checking       Savings

#### Bank Information

Name \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

We will not draft from your account until underwriting approves your application.

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of Standard Life and Accident Insurance Company, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to 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 checks. I further agree should any such checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. If this application is taken over the phone, I agree that my electronic signature serves as my original signature.

\_\_\_\_\_  
Date Signed



\_\_\_\_\_  
Signature (as it appears on bank records)

Complete if no personalized deposit ticket is available.

Account Number \_\_\_\_\_

Routing Number \_\_\_\_\_

SLA-HIAPP10WA

# HOSPITAL INDEMNITY APPLICATION



**Standard Life and Accident Insurance Company**

Mailing Address:  
P.O. Box 696870, San Antonio, TX 78269  
888.350.1488

SLA-HIAPP10WA

ST-2504

**Standard Life and Accident Insurance Company**  
**Mailing Address:** P.O. Box 696870 • San Antonio, TX 78269 • 888.350.1488

**HOSPITAL INDEMNITY INSURANCE APPLICATION** Please Print — Use Black Ink  New Policy  Reinstatement

**SECTION A**

1. Please print the full name of all Proposed Insureds (Use additional sheet and attach if needed).

Last, First, Middle Initial	Social Security Number	Relationship	Sex M/F	Date of Birth Month, Day, Year	Age	Height (ft.-in.)	Weight (lbs.)
A.		Applicant					
B.		Spouse/ Domestic Partner					
C.							
D.							

2. Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 Phone: Home (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

3. PREMIUM DATA	Amount	Premium	Mode:
Hospital Admission Benefit:	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000	\$ _____	<input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual
Hospital Confinement Benefit:	\$ _____/Day	\$ _____	<input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly PAC
Total Billable Premium:		\$ _____	Method: <input type="checkbox"/> Direct <input type="checkbox"/> Salary Deduction
			Franchise Name _____
			Franchise Number _____

4. Has any Proposed Insured ever been declined, restricted, rated-up, or postponed for any kind of life or health insurance with this or any other company? .....  Yes  No  
 If Yes, give details: \_\_\_\_\_

5. Does any Proposed Insured currently have more than one Medical Expense and/or Hospital Indemnity Policy with this or any other company? .....  Yes  No  
 If Yes, please name company and give details in chart below:

Plan Type	Company	To Be Replaced?	Plan Type	Company	To Be Replaced?
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION B** (Proposed Insured is not eligible for Hospital Indemnity insurance if any question in SECTION B is answered "Yes".)

- 6. Is any Proposed Insured or family member of the household an expectant mother or expectant father?.....  Yes  No
- 7. Within the past 2 years, has any Proposed Insured had symptoms, treatment or been recommended to have treatment for: Addison's Disease, Alzheimer's, Internal Cancer, COPD, Connective Tissue Disorder, Chronn's Disease, Cystic Fibrosis, Dementia, Insulin Dependent Diabetes, Emphysema, Heart Attack, Heart Disease, Heart Bypass, Heart Stents, Hepatitis, Cirrhosis of the Liver, Hodgkins, End Stage Renal Disease, Leukemia, Lupus, Multiple Sclerosis, Muscular Dystrophy, Organ Transplant (except corneal), Parkinson's, Paralysis, Peripheral Vascular Disease, Stroke, TIA or Amyotrophic Lateral Sclerosis (ALS)? .....  Yes  No
- 8. Has any Proposed Insured been diagnosed by a physician, or tested positive or treated for HIV, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?.....  Yes  No
- 9. Has any Proposed Insured been advised to be admitted to a hospital, nursing home, clinic, or other institution for diagnosis or treatment or had surgery or medical tests recommended, but not yet performed? .....  Yes  No



**AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION**

I hereby authorize any: physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policyholder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on STANDARD LIFE AND ACCIDENT INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other Proposed Insured for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Proposed Insured. It is understood that STANDARD LIFE AND ACCIDENT INSURANCE COMPANY underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it, resulting in loss of protection by federal regulations.

I understand that: **1.** such information will be used by STANDARD LIFE AND ACCIDENT INSURANCE COMPANY for underwriting and insurability determinations; **2.** I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain health insurance coverage; **3.** a picture copy or photocopy of this authorization shall be as valid as the original; and **4.** I, or my authorized representative, am entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, P.O. Box 1991, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under this authorization, if signed.* If this application is taken over the phone, I agree that my electronic signature serves as my original signature.

Signed at \_\_\_\_\_  
City and State

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Spouse/Domestic Partner's Signature  
(if coverage is requested for spouse/domestic partner)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Personal Representative designated by signature above is hereby authorized to execute this instrument based on: (circle one) power of attorney, guardian, guardian-in-fact, payee representative or other \_\_\_\_\_.

## PRODUCER STATEMENT

I have verified the Applicant's identity through a U.S. federal or state government-issued I.D. such as driver's license, government-issued I.D., passport, visa, etc. ...  Yes  No

I have inquired about and have personal knowledge of the medical history of each Proposed Insured.

\_\_\_\_\_  
Producer's Name (please print)

\_\_\_\_\_  
Producer's Signature

\_\_\_\_\_  
Producer's Code

Phone (        ) \_\_\_\_\_

Fax (        ) \_\_\_\_\_

Email Address \_\_\_\_\_

Cash collected with Application: \$ \_\_\_\_\_

No money collected. Initial premium is to be drafted.

Mail Policy to:  Applicant  Producer

Special Request: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# HOSPITAL INDEMNITY PLAN ANNUAL PREMIUM RATES

Issue Ages: 0-74

## BASE PLAN

Age	Individual	Two Adults	One Parent Family	Two Parent Family
Under 39	\$168.00	\$ 241.00	\$301.00	\$ 374.00
40-49	230.00	353.00	397.00	520.00
50-59	325.00	525.00	425.00	625.00
60-64	454.00	758.00	521.00	825.00
65-69	602.00	1,029.00	665.00	1,093.00
70-74	771.00	1,335.00	834.00	1,398.00

## ADDITIONAL \$500 OF HOSPITAL ADMISSION BENEFIT

Age	Individual	Two Adults	One Parent Family	Two Parent Family
Under 39	\$ 32.00	\$ 56.00	\$ 74.00	\$ 98.00
40-49	54.00	100.00	108.00	152.00
50-59	84.00	154.00	116.00	184.00
60-64	126.00	230.00	148.00	250.00
65-69	210.00	382.00	230.00	402.00
70-74	284.00	514.00	304.00	534.00

## EACH ADDITIONAL \$100 DAILY ROOM BENEFIT

Age	Individual	Two Adults	One Parent Family	Two Parent Family
Under 39	\$ 59.00	\$107.00	\$151.00	\$199.00
40-49	97.00	176.00	212.00	291.00
50-59	163.00	294.00	231.00	363.00
60-64	250.00	452.00	295.00	498.00
65-69	317.00	574.00	361.00	617.00
70-74	413.00	748.00	457.00	791.00

## MODAL FACTORS

Monthly PAC 0.0875	Quarterly 0.27	Semi-Annual 0.52
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