Standard Security Life Insurance Company of New York
Home Office: 485 Madison Ave, New York, NY 10022
Submit Application to:
1173 W. Main St., Ste. E., Whitewater, WI 53190
Fax 1-866-570-5234 • Phone 1-866-472-6555

Standard Security Life Insurance Company
Independence Holding Group

APPLICATION FOR INDIVIDUAL CRITICAL ILLNESS INSURANCE

I. APPLICANT(S)

Applicant's Name *(First, Middle, Last)*		**SSN**
Date of Birth *(mo/day/year)*	**State of Birth**	**Phone No.(s)**
Is the Applicant a permanent, legal resident of the United States? ☐ Yes ☐ No		
If the Applicant has a permanent resident Green Card, please list the number:		
Height *ft.* *in.*	**Weight** *lbs.*	**Gender** ☐ M ☐ F
In the last 12 months, has the Applicant used tobacco of any kind? ☐ Yes ☐ No		
Applicant's Street Address *(including City, State, ZIP)*		
Mailing Address *(including City, State, ZIP)*, **if different than above**		**Mail Policy Documents to:** ☐ Agent ☐ Applicant
Spouse's Name *(First, Middle, Last)*, **if applying for insurance**		**Spouse's SSN**
Date of Birth *(mo/day/year)*	**State of Birth**	**Phone No.(s)**
Is the Applicant a permanent, legal resident of the United States? ☐ Yes ☐ No		
If the Applicant has a permanent resident Green Card, please list the number:		
Height *ft.* *in.*	**Weight** *lbs.*	**Gender** ☐ M ☐ F
In the last 12 months, has the Spouse used tobacco of any kind? ☐ Yes ☐ No		

Child Coverage, **if applying for insurance (please fill out completely)** *(attached separate sheet if more space is needed)*

Name *(First, Middle, Last)*	**Date of Birth** *(mo/day/year)*	**Gender**	**Height** *(feet/inches)*	**Weight** *(pounds)*
		☐ M ☐ F		
		☐ M ☐ F		
		☐ M ☐ F		
		☐ M ☐ F		
		☐ M ☐ F		

Any applicant applying for any specified disease (critical illness) insurance may not be covered by the Federal Medicaid program (Title XIX). **Is any applicant listed above currently covered by the Federal Medicaid program (Title XIX)? If "Yes", please list name(s):** ☐ Yes ☐ No

Requested Effective Date: *(choose 1st or 15th and state the month)* ☐ 1st or ☐ 15th of:

II. HEALTH QUESTIONS - The terms "diagnosed", "advised" and "treatment" mean any medical diagnosis, medical treatment or medical advice received by a licensed member of the medical profession.	
This section applies to any applicant applying for coverage. For any "Yes" answer, please list the applicant's name and question number(s) on page 3.	
In the last 10 years, has any applicant had symptoms of, received abnormal diagnostic test results related to, been diagnosed with, received or been advised to receive, treatment for any of the following:	
1. Heart attack, Aortic or heart valve surgery, Angioplasty or Coronary Artery Bypass?	☐ Yes ☐ No
2. Stroke or Transient Ischemic Attack (TIA)?	☐ Yes ☐ No
3. Cancer or Leukemia (excluding basal or squamous cell carcinoma of the skin)?	☐ Yes ☐ No
4. End-Stage Renal Disease (ESRD)?	☐ Yes ☐ No
5. Major organ failure or bone marrow transplant?	☐ Yes ☐ No
6. Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes ☐ No
7. Alzheimer's disease, dementia or amyotrophic lateral sclerosis (ALS) muscular dystrophy, chorea or other disease affecting the central nervous system?	☐ Yes ☐ No
8. Multiple Sclerosis (MS)?	☐ Yes ☐ No
9. Cirrhosis of the liver?	☐ Yes ☐ No
10. Hepatitis B, Hepatitis C or is a carrier of Hepatitis?	☐ Yes ☐ No
11. Alcoholism, drug or substance abuse?	☐ Yes ☐ No
12. Diabetes (other than during pregnancy)?	☐ Yes ☐ No
In the last 5 years, has any applicant had symptoms of, received abnormal diagnostic test results related to, been diagnosed with, received or been advised to receive, treatment for any of the following:	
13. Heart disease, including Angina (excluding mitral valve prolapse not requiring medication or treatment, and innocent (functional) heart murmurs)?	☐ Yes ☐ No
14. Kidney disease (excluding non-recurrent kidney stones or and non-chronic infections)	☐ Yes ☐ No
15. Liver disease?	☐ Yes ☐ No
16. Lung disease (excluding non-chronic bronchitis, asthma, and a single episode of pneumonia that has not required hospitalization)?	☐ Yes ☐ No
17. Disease of the nervous system (excluding non-chronic shingles)?	☐ Yes ☐ No
18. Colitis, disease or disorder of the pancreas, or Crohn's disease (excluding mucus colitis and irritable bowel syndrome)?	☐ Yes ☐ No
19. Recurrent tumors or unexplained tumors or growth, precancerous lesions/tumors, polyps, dysplastic nevi (atypical moles), or abnormal moles or lesions?	☐ Yes ☐ No
20. Basal or squamous cell carcinoma of the skin?	☐ Yes ☐ No
21. Fibrocystic breast disease or an *abnormal* PSA test, Pap smear or mammogram?	☐ Yes ☐ No
22. Hypertension which has averaged over 150/90 or (within the last one year) has required more than one medication to control?	☐ Yes ☐ No
23. Hyperlipidemia with cholesterol levels averaging over 300 mg and/or triglyceride levels averaging over 350 mg or (within the last one year) has required more than one medication to control?	☐ Yes ☐ No
24. Recurrent Human Papillomavirus (HPV) or a sexually transmitted disease?	☐ Yes ☐ No
In the last 5 years, has any applicant:	
25. Lost the ability to perform any of the following activities independently: dressing, bathing, feeding, toileting or continence, or transfer in or out of a chair or bed?	☐ Yes ☐ No
Has any applicant had two or more natural parents or brothers or sisters (living or deceased) who were diagnosed with the same medical condition, as follows:	
26. Diagnosed before age 60 of cancer, heart disease, diabetes, stroke or kidney disease?	☐ Yes ☐ No
27. Diagnosed before age 75 of colorectal cancer, Alzheimer's disease or dementia?	☐ Yes ☐ No

II. HEALTH QUESTIONS *continued…*

For any "Yes" answer on page 2, please list applicant's name and question number(s) here:

Applicant Name(s)	Question Number(s)

If an answer was marked "Yes" to any questions on page 2, for an applicant listed above, that applicant is not eligible for Critical Illness Insurance.

III. BENEFIT AMOUNT

Please complete the Benefit Amount you are applying for:

Primary Applicant	Spouse Applicant	Dependent Child Applicant(s)
$	**$**	□ $10,000 per covered Child

IV. PREMIUM

Premium – Total Amount	Payment Mode
$	□ Annual □ Semi-Annual □ Quarterly □ Monthly

Payment Type

□ Bank Draft (O Checking or O Savings) □ Credit Card □ Other:

ALL PREMIUM CHECKS MUST BE MADE PAYABLE DIRECTLY TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK. NO MONEY ORDERS ACCEPTED.

V. EXISTING INSURANCE/REPLACEMENT - Questions & Signatures

Applicant and Spouse:

- Do you understand this is an Application for a Critical Illness Insurance Policy and not a major medical insurance policy? □ Yes □ No
- **Do you acknowledge receipt of the "Notice to Proposed Insured" and the Critical Illness Outline of Coverage?** □ Yes □ No
- Do you have any existing accident or sickness insurance policies? □ Yes □ No
- If "Yes", do you intend to replace any accident or sickness insurance policies? □ Yes □ No
  If "Yes", the Agent will present a disclosure about Replacement of coverage.

Agent: To the best of your knowledge,

- Do the Applicant(s) have any existing accident or sickness insurance? □ Yes □ No
- Is the critical illness insurance applied for intended to replace any existing accident or sickness insurance? *If "Yes", you must present to the Applicant(s) the required Replacement disclosure.* □ Yes □ No

Applicant Signature	**Signature Date**
Spouse Signature	**Signature Date**
Agent Signature	**Signature Date**

VI. APPLICANT UNDERSTANDING AND SIGNATURE

- My statements made on this Application are true, complete, and correct to the best of my knowledge and belief.
- I understand that any representative I appoint, prior to acting on my behalf, will need to submit power of attorney documents, or other legal documents, to the Company.
- I hereby authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy provider, Veterans Administration Facility, or other medical or medically related facility, state or local government agency, insurance or reinsurance company, Medical Information Bureau, Inc. (MIB), consumer reporting agency, or employer, to give to the Company, its legal representative or its reinsurers the following information to use for underwriting insurance: diagnosis, treatment and prognosis with respect to any physical or mental condition, employment, other insurance coverage, and claims history.
- I understand that any information disclosed pursuant to this Authorization may be retained and re-disclosed and no longer covered by Federal rules governing privacy and confidentiality of health information.
- I understand the Company may use this information for the purpose of evaluating my Application; make eligibility, risk rating and policy issuance determinations; obtain reinsurance; and administer insurance benefits (no information collected concerning the sexual orientation of any Applicant will be used to determine eligibility for insurance).
- I have the right to be interviewed as part of the application process and I may contact the Company for further information.
- I, or my authorized representative, may request a copy of any consumer report and receive specific reasons for any adverse underwriting decision, including items or medical records, where applicable or allowed, to support such decision, as well as the name and address of the source. We also have the right to dispute, correct, amend or delete the portion of the recorded personal information in dispute.
- I agree that this Authorization, in connection with this form, shall be valid for 30 months from my signature date or for the duration of the claim if information is being collected in connection with a claim for a benefit. I understand that I, or my authorized representative, have the right to revoke this Authorization at any time. I understand that any revocation request of this Authorization will need to be in writing by sending a written request to the Company.
- I agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me or my authorized representative upon request.
- I understand I must be a permanent, legal resident of the United States in order have this Critical Illness Insurance.
- **I understand the Critical Illness Insurance Policy provides limited benefits and I should review the Policy carefully upon receipt.**

<u>WARNING:</u> Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines, confinement in prison and/or denial of insurance benefits.

Applicant Signature	**Signature Date**	**Dated at this City & State**
Spouse Signature	**Signature Date**	**Dated at this City & State**

VII. AGENT CERTIFICATION AND SIGNATURE

To the best of your knowledge and belief:

- Was the Applicant's signature witnessed by you? ☐ Yes ☐ No
- Did you truly and accurately record on this Application the information provided by the Applicant? ☐ Yes ☐ No
- **Did you deliver the required "Notice to Proposed Insured" and the Outline of Coverage?** ☐ Yes ☐ No

Name of Agent (typed/printed)	**Agent Signature**	**Agent % Split**

Dated at this City & State	**Date**	**SSL Agent No.**	**Phone No.**

Name of Agent (typed/printed)	**Agent Signature**	**Agent % Split**

Dated at this City & State	**Date**	**SSL Agent No.**	**Phone No.**

Agent Comments/Notes:	Company Use Only

Home Office Comments:

Standard Security Life Insurance Company of New York

NOTICE TO PROPOSED INSURED

MIB, Inc. Notice

Information regarding your insurability will be treated as confidential. Standard Security Life Insurance Company of New York or its reinsurer(s) may, however, make a brief report thereon to MIB, Inc. (MIB), a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB will, upon request, supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Call MIB's toll-free telephone number 1-866-692-6901 (or TTY 1-866-346-3642, for the hearing impaired) and the information shall be disclosed either directly to you or to a medical professional, whichever you prefer. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

Standard Security Life Insurance Company of New York or its reinsurer(s) may also release information in its file to other life insurance companies to whom you apply for life or health insurance, or to whom a claim may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Payment Authorization

Automatic payment authorization for critical illness insurance coverage

Standard Security Life Insurance Company
Independence Holding Group

Primary applicant name: _____

This form must be completed in order for your Critical Illness Insurance to be paid automatically through bank draft or credit card charge.

- If you have selected monthly billing mode, choose Bank Account Draft or Credit Card Charge below and complete the appropriate information. Your first payment and all future payments will be completed through the selected monthly automatic method.
- If you have selected a quarterly, semi-annual or annual billing mode, please submit a check for the first premium with the application. You will be mailed a billing statement for future payments. This form is not required.

Bank Account Draft

Account type ❑ Checking ❑ Savings	Name of account holder (please print)	Name of bank	
Bank address	City	State	ZIP code
Routing number	Account number		

Credit Card Charge

Card type ❑ MasterCard ❑ Visa	Name—as it appears on the card	
Card number	Expiration date	

Standard Security Life Insurance Company of New York, or its designated administrators, is hereby authorized to debit my bank account or charge my credit card noted above for the purpose of paying critical illness insurance premiums and fees, if applicable. If I have selected a quarterly, semi-annual or annual billing mode on my application for individual critical illness insurance, Standard Security is authorized charge my credit card for only the initial modal payment. If I have selected a monthly billing mode, Standard Security is authorized to draft my account or charge my credit card each month thereafter until this authorization is terminated. I understand that the applicable initial premiums collected will be refunded to me if my critical illness insurance policy is not issued. I agree that the above named financial institution shall be fully protected in honoring any such payments. The institution's rights and treatment of each payment shall be the same as if it were signed by me. If any such payment is dishonored, whether with or without cause, I understand that the institution shall not be liable whatsoever, even though such dishonor results in a forfeiture of insurance. If monthly billing mode was selected, this authorization will remain in effect until notification of termination in writing is given by me in such a time and manner as to give Standard Security Life and the financial institution a reasonable opportunity to act on it (generally 30 days).

A $25 service fee will be assessed for each dishonored payment. If necessary, I agree to pay this fee in addition to the amount of the payment due.

Signature(s)

I agree to the terms outlined above and authorize Standard Security Life to initiate payment for critical illness insurance. I understand that coverage purchased by bank draft is subject to clearance by the bank and coverage purchased by credit card is subject to acceptance of the credit card issuer.

X _____ _____

Signature of primary applicant — Date

Additional signature required if the accountholder is someone other than the primary applicant:

X _____ _____

Signature of accountholder/cardholder — Relationship to primary applicant

Standard Security Life Insurance Company of New York

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to information you have furnished in the Application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Standard Security Life Insurance Company of New York. For your own information and protection, you should be aware of, and seriously consider, certain factors that may affect the insurance protection available to you under the new policy. The Standard Security Life Insurance Company of New York **Policy is Critical Illness Insurance only and is designed to provide restricted coverage paying benefits ONLY when certain losses occur as a result of a specified Critical Illness**.

Coverage is NOT provided for basic hospital, basic medical-surgical, or major medical expenses.

(1) Critical Illnesses which you may presently have are not covered under the new Policy. This will result in denial 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 the new Policy, 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 an Application may provide a basis for Standard Security Life Insurance Company of New York to deny any future claims and to refund your premium as though the 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.

This "Notice to Applicant Regarding Replacement of Accident and Sickness Insurance" was delivered to me on:

_____ _____

Date Applicant's Signature

_____ _____

Date Spouse's Signature

Standard Security Life Insurance Company of New York
485 Madison Avenue, New York, NY 10022 • Phone: 1-212-355-4141

CRITICAL ILLNESS INSURANCE OUTLINE OF COVERAGE

For Critical Illness Insurance Policy Form No. ICI-P-0211

This Outline of Coverage provides a brief description of the important features of Our Critical Illness Insurance Policy (Policy). **This is not the contract of insurance and was only designed to outline the benefits and limitations of the actual Policy** that would be issued upon Your Application and Our approval. The Policy itself details the rights and obligations of both You and Us. Therefore, it is important that you READ THE POLICY CAREFULLY upon its issuance, if issued. The Policy provides a 30 day time period in which You can review and return the Policy for a refund of any premiums paid.

Critical Illness insurance is also called "**specific disease**" insurance. This type of insurance is designed to provide limited benefits. **CRITICAL ILLNESS INSURANCE IS NOT MAJOR MEDICAL INSURANCE, MEDICARE SUPPLEMENT INSURANCE OR LIFE INSURANCE.**

BENEFITS:
Critical Illness benefits are payable for first ever occurrences, Diagnoses or procedures that occur after the Insured Person's Effective Date of insurance. The occurrence, Diagnosis or procedure is the first time ever, in the Insured Person's lifetime, that he or she has experienced a covered Critical Illness, been Diagnosed with a specific, covered Critical Illness or undergone a specific procedure for a covered Critical Illness. Upon receipt of proper Proof of Claim, benefits will be paid immediately.

Reduced Cancer Benefit - If Invasive Cancer or Cancer In Situ is Diagnosed within the first 90 days beginning on the Policy's Effective Date, the Benefit Payment will be reduced as shown in the below percentages.

CRITICAL ILLNESS DIAGNOSIS	BENEFIT PAYMENT PERCENTAGE
CATEGORY I	
Invasive Cancer (Diagnosed more than 90 days after the Effective Date)	100%
Invasive Cancer (Diagnosed during the first 90 days of In-Force insurance)	10%
Cancer In Situ (Diagnosed more than 90 days after the Effective Date)	25%
Cancer In Situ (Diagnosed during the first 90 days of In-Force insurance)	2.5%
CATEGORY II	
Heart Attack (Myocardial Infarction)	100%
Stroke	100%
Major Organ Failure of the heart or combination failure including heart	100%
Coronary Artery Bypass	25%
Angioplasty	10%
CATEGORY III	
Major Organ Failure not covered in CATEGORY II	100%
End Stage Renal Disease	100%
Severe Burn *(for Insured and Spouse only)*	100%
Coma	100%
Paralysis	100%

Benefit Payment - Benefits will be paid in one lump sum.

Multiple Payment Benefit - This feature allows for Multiple Payments from the three Categories of Critical Illnesses. The Benefit Payment under each Category shall not exceed 100% of the Benefit Amount Per Category.
You can receive a Benefit Payment on a second or third Critical Illness if that Critical Illness meets the terms and conditions of the Policy. After a Benefit Payment in one Category, the Insured can choose to continue paying Premiums, for an Insured Person, and possibly receive additional Benefit Payments if another Critical Illness occurs. The Maximum Benefit Amount is three times the Benefit Amount Per Category. Once 100% of the Maximum Benefit Amount has been paid for an Insured Person, insurance for the Insured Person terminates and no further benefits are payable.

ELIGIBILITY FOR CRITICAL ILLNESS INSURANCE:

- Each Applicant and Spouse (if a Spouse is applying) must complete an Application For Individual Critical Illness Insurance (subject to underwriting and approval by Us).
- Each Applicant and Spouse must be between the ages of 18 and 64 and be a permanent, legal resident of the United States.

PREMIUM, RENEWABILITY, WHEN COVERAGE ENDS:

- **Guaranteed Renewable** - This Policy is renewable as long as the Premium is paid on or before the due date or within the Grace Period.
- **Premium changes** - We may change the Premium payable for this Policy. Premium rates are guaranteed for a period not less than 12 months and any rate revisions will first be filed (by Us) with the North Carolina Commissioner of Insurance. We will provide advance notice when there is a change in Premium.
- **When Insurance Ends** - Insurance under this Policy will terminate at the earlier of: (i) the time Premium is not paid, as described in section "Premium Provisions"; (ii) for any Insured Person, upon written request by the Insured; (iii) for any Insured Person, the date he or she reaches the Maximum Benefit Amount; (iv) for any Insured Person, the date he or she is deceased; (v) for any Insured Person, the date he or she is no longer a permanent, legal resident of the United States; (vi) for the Insured, the date he or she attains age 75; and (vii) for the Spouse, the date he or she attains age 75.

GENERAL EXCLUSIONS:

This Policy does not cover any Critical Illness caused in whole or in part by, or resulting in whole or in part, from the Insured Person's:

- commission of or attempt to commit a felony.
- intentional self-inflicted injury or sickness.
- alcoholism or drug addiction.
- being intoxicated or under the influence of an illegal substance or a narcotic (unless prescribed by a Physician to the Insured Person). Intoxication is determined by the laws of the state where the incident occurred.
- attempting or committing suicide.
- illness or injury that is not specifically set forth in and covered under this Policy.

CHILD BENEFIT RIDER:

The Child Benefit Rider adds the Insured's Children to the Insured's Critical Illness Insurance Policy. The term "Child" refers to the Insured's newborn child, natural child, step child, legal ward, foster child and adopted child, including a child placed with the Insured for the purpose of adoption, from the moment of birth or date of placement as certified by the agency make the placement, or a Child that is not capable of self-sustaining employment because of mental retardation or physical handicap, and is chiefly dependent on the Insured for support and maintenance. A dependent Child: (i) must be between birth and age 25, (ii) must be a permanent, legal resident of the United States, and (iii) the Insured must complete, for the Child, an Application For Individual Critical Illness Insurance (subject to underwriting and approval by Us). Critical Illness Insurance under the Policy will terminate at the earlier of: (i) the date the Policy terminates; (ii) the time Premium is not paid, as described in section "Premium Provisions"; (iii) upon written request by the Insured; (iv) the date the Child reaches the Maximum Benefit Amount; (v) the date the Child attains age 25 or gets married (as described in this Rider's section "Definitions"); (vi) the date the Child is deceased; or (vii) the date the Child is no longer a permanent, legal resident of the United States. **There is NO Severe Burn insurance benefit available for Children.**

Online Fulfillment
Supplemental Form

In an effort to protect the environment and conserve resources, online fulfillment is available with Critical Illness Insurance plans underwritten by Standard Security Life Insurance Company of New York. If your application for coverage is approved, how would you like to obtain your policy documents?

❑ Online: Your policy documents and other correspondence will be available on a secured website. You will receive an email including the Web address and your login information.

❑ U.S. Mail: Your policy documents and other correspondence will be packaged and sent through the U.S. Postal Service.

Name of applicant

Email address

Signature of applicant

Date