

ARKANSAS BENEFIT SELECTION SHEET

Please mark the appropriate plan, deductible, coinsurance, and optional benefit(s) desired.
 Submit this with your Application. Availability is subject to Underwriting approval.

Proposed Insured (Print): _____ Date: _____

Unlimited Access Plan

Any Doctor / Any Hospital

Deductible

\$500 \$1,000 \$2,500 \$5,000

Optional Benefits

- Maternity Benefit
- Dental Benefit
- AD&D
- Enhanced Prescription Drug Card

Mandated Offers

- Alcohol & Drug Dependency

HealthSelect PPO Plan

Preferred Provider (PPO)

Deductible

\$1,000 \$1,500 \$2,500 \$5,000

Optional Benefits

- Maternity Benefit
- Dental Benefit
- Enhanced Prescription Drug Card

Mandated Offers

- Alcohol & Drug Dependency

Preferred Value Plan

High Deductible (HDHP)

Deductible

\$1,500 \$2,500 \$5,000 \$10,000

Optional Benefits

- Enhanced Prescription Drug Card

Mandated Offers

- Alcohol & Drug Dependency

Healthy Savings Plan

HSA-Qualified

Deductible

Individual	Family
<input type="checkbox"/> \$1,500	<input type="checkbox"/> \$2,500
<input type="checkbox"/> \$2,500	<input type="checkbox"/> \$5,000
<input type="checkbox"/> \$3,750	<input type="checkbox"/> \$7,500
<input type="checkbox"/> \$5,000	

Optional Benefits

- Maternity Benefit

Mandated Offers

- Alcohol & Drug Dependency

Coinsurance Options

- 100%
- 80/20 to allowable max.
(Only available with \$1,500 or \$2,500 deductible)

Additional Options

Term Life Rider

(Not Available on Preferred Value Plan)

- | | |
|---|---|
| <input type="checkbox"/> Proposed Insured | <input type="checkbox"/> Insured's Spouse |
|---|---|

Benefit

<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$10,000
<input type="checkbox"/> \$20,000	<input type="checkbox"/> \$20,000
<input type="checkbox"/> \$30,000	<input type="checkbox"/> \$30,000
<input type="checkbox"/> \$40,000	<input type="checkbox"/> \$40,000
<input type="checkbox"/> \$50,000	<input type="checkbox"/> \$50,000

Cancer Policy

- Individual Plan
- Single Parent Plan
- Family Plan

Benefit Amount

- \$10,000 \$40,000
- \$20,000 \$50,000
- \$30,000

Disability Income Policy

Monthly Benefit: _____
 (from \$400 - \$3,000)

Elimination Period: 7 Days 14 Days 30 Days
 60 Days* 90 Days* *(5 year plan only)

Benefit Period: 6 Months 12 Months 24 Months
 60 Months* *(only available to P Class)

Occupation Class: Professional (P) Accidental (A)
 Manual Labor (B)

*Billing Fees: Annual \$0 Semi-Annual \$10 Quarterly \$10 Monthly Direct \$10
 Credit Card \$10 PAC \$2 Convenience Bill \$10

\$ _____ + \$ **25** + \$ _____ + \$ _____ = Total Remitted
 Modal Premium + Application Fee + *Billing Fee

Please submit the premium, billing fee, and application fee (refundable if insurance is denied, withdrawn or policy is not taken) with your application. Make check payable to United Security Life & Health.

APPLICATION FOR INSURANCE



6640 S. Cicero Avenue
Bedford Park, IL 60638 • 800/875-4422

NEW INSURANCE

Requested Effective Date (1st thru 28th only) _____

ADD ON APPLICATION

Month _____ Day _____

PROPOSED INSURED(S)

(Please include Maiden name) (First, MI, Last)

	Social Security #	Sex	Date of Birth	Age	State of Birth	Marital Status	Height	Weight	Tobacco Use
1. Primary Insured <input type="checkbox"/> Uninsured Applicant									<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Spouse									<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Dependents									Full Time Student
A. _____									<input type="checkbox"/> YES <input type="checkbox"/> NO
B. _____									<input type="checkbox"/> YES <input type="checkbox"/> NO
C. _____									<input type="checkbox"/> YES <input type="checkbox"/> NO
D. _____									<input type="checkbox"/> YES <input type="checkbox"/> NO
E. _____									<input type="checkbox"/> YES <input type="checkbox"/> NO

YES NO If No, explain below. The parent where Dependent(s) reside must also sign this application.

4. Residence Address

Street _____ City _____ State _____ Zip _____

Day Time Phone Number _____ / Cell Number _____ Best Time to Call _____ E-mail address _____

5. Billing Address (if different than above)

Street _____ City _____ State _____ Zip _____ Phone Number _____

6. Occupation

Primary Insured – Employer Name _____ Spouse – Employer Name _____

Duties _____ Monthly Earned Income _____ Duties _____ Monthly Earned Income _____

7. Beneficiary (if applying for Life Insurance) If none listed, Beneficiary will be the Estate of the Insured

Primary Insured:

Primary	Relation to Insured	Contingent	Relation to Insured
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Spouse:

Primary	Relation to Insured	Contingent	Relation to Insured
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8. Do you or any Proposed Insured have any health insurance coverage currently in force or pending? YES NO
Name of Company _____ Type of Coverage _____

9. Is this plan of insurance intended to replace any insurance in force? YES NO

10. Has any Proposed Insured ever participated in any of the following occupations/avocations/activities: Aviation, ATV Riding, Bungee Jumping, Crop Dusting, Hang Gliding, Horse Riding, Martial Arts (over age 15), Motorcycle/Motorbike Riding, Motorized Vehicle Racing, Mountain/Rock Climbing, Parachuting, Parasailing, Professional/Semi-professional/Collegiate Athletics, Rodeo Activities, SCUBA Diving, Skydiving? If YES, provide complete details in # 24. YES NO

11. Have any of the Proposed Insureds ever had a driver's license suspended, revoked, been cited for driving while intoxicated, had two or more violations in the past two years or been licensed to operate a motorcycle? YES NO
If YES, Proposed Insured: _____ Driver's License #: _____ State Issued: _____

Details: _____

12. Has every Proposed Insured been a legal resident of the United States for the past year? If NO, give details: YES NO

MEDICAL HISTORY (All health questions must be answered)

- 13.** Is any family member (whether applying for coverage or not) currently pregnant, an expectant parent, or in the process of adopting a child?
IF YES, NO FAMILY MEMBER IS ELIGIBLE FOR COVERAGE, even if the pregnant individual is not applying for coverage. YES NO
- 14.** Has any Proposed Insured ever been told by a medical professional that they have, been diagnosed with, or been treated for Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC) or tested positive for HIV or HTLV III? YES NO
- 15.** Has any Proposed Insured had any symptoms, testing, treatment, diagnosis, been prescribed medication for or had a consultation with a medical professional for any of the following physical systems, organs, illnesses, injuries, diseases, or disorders? – **Check all that apply.**
- 15A. Respiratory System** YES NO
If YES, Check all that apply
 Allergies Asthma Bronchitis Emphysema/COPD Pneumonia Sinusitis
 Chronic Cough Tuberculosis Shortness of Breath Sleep Apnea Other Lung Disorder
- 15B. Circulatory System** YES NO
If YES, Check all that apply
 Heart Disease Coronary Artery Disease High Blood Pressure Elevated Cholesterol/Triglycerides
 Varicose Veins Irregular Heartbeat Chest Pain Heart Murmur
 Stroke/TIA Phlebitis Blood Clot Blood Disorder Poor Circulation
- 15C. Digestive System** YES NO
If YES, Check all that apply
 Ulcers Gastritis Colitis Stomach Gallbladder/Gall Stones
 Hernia Hemorrhoids Spleen Bleeding Esophagus/Reflux/GERD
 Pancreas Liver/Bile Ducts Hepatitis (A ____, B ____, C ____) Intestinal Disorder
- 15D. Endocrine System** YES NO
If YES, Check all that apply
 Pancreas Diabetes Abnormal Blood Glucose Pituitary Other Gland Disorder
 Thyroid Goiter Addison's Disease Sugar in the Urine
- 15E. Reproductive System (Male/Female)** YES NO
If YES, Check all that apply
 Ovaries/Ovarian Cyst Caesarean Section Miscarriage Menstrual Disorder
 Infertility Cervix Abnormal PAP Herpes
 Endometriosis Uterus/Uterine Fibroids Genital Warts Prostate/Elevated PSA Sexually Transmitted Diseases
- 15F. Urinary System** YES NO
If YES, Check all that apply
 Kidney Stone/Disorder Bladder Stones Bladder Prostate Urinary Tract Infection
- 15G. Musculo-Skeletal System** YES NO
If YES, Check all that apply
 Back/Spine/Vertebrae Fibromyalgia Arthritis Rheumatism Gout
 Foot/Knee Disorder TMJ/Jaw Disorder Lupus Herniated/Slipped Disc
 Arm/Shoulder Disorder Joint Disorder/Replacement Bursitis Collagen Vascular Disorder
 Connective Tissue Disorder Muscle/Ligament/Tendon/Cartilage Disorder Spinal Manipulation/Adjustment
- 15H. Nervous System** YES NO
If YES, Check all that apply
 Epilepsy Convulsions Seizures Paralysis Parkinson's Disease
 Head Injury Brain Disorder Dementia Headaches/Migraines Alzheimer's Disease Neuropathy
- 15I. Mental/Nervous System** YES NO
If YES, Check all that apply
 Anxiety/Depression Attention Deficit/ADD/ADHD Neurosis/Psychosis Sleep Disorder
 Bi-Polar Disorder Chemical Imbalance Psychiatric Treatment or Counseling Eating Disorder
- 16.** Has any Proposed Insured had any symptom, consulted with, received medical care or advice from, been diagnosed or treated, had surgery for or received any prescription medication from any member of the medical profession for any condition or illness not listed above? YES NO
- 17.** Has any Proposed Insured received treatment for cancer, melanoma, leukemia, tumor/growth, skin cancer, or cyst? YES NO
- 18.** Has any Proposed Insured, in the past five years, taken any prescription medication or received any medical treatment? ... YES NO
- 19.** Has any Proposed Insured been advised by a medical professional to have surgery, treatment, testing or hospitalization and not done so?..... YES NO
- 20.** Has any Proposed Insured had any diagnosis related to, received treatment for, been advised to seek treatment, been told to decrease or discontinue alcohol consumption, used illegal drugs, or been hospitalized due to alcohol or drug use/abuse? YES NO
- 21.** Has any Proposed Insured used, or is currently using, any tobacco products?..... YES NO
If YES, but not currently using, date last used: _____
- 22.** Has any Proposed Insured experienced a weight change of more than 10% of his/her current weight in the past year? YES NO
- 23.** Does any Proposed Insured currently have any internal fixations (i.e. screws, plates) or implants of any kind? YES NO

If you answered "YES" to question #9, you must complete this section.

Notice To Applicant Regarding Replacement of Health Insurance

According to information you have furnished, you intend to lapse or otherwise terminate existing health insurance and replace it with a Certificate to be issued by United Security Life and Health Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new Certificate.

1. Health conditions which you may presently have, which may be referred to in the policy as pre-existing conditions, may not be immediately or fully covered under this new Certificate. This could result in denial or delay of a claim for benefits under this new Certificate, whereas a similar claim might have been payable under your present coverage.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. 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 coverage and replace it with new coverage, 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 THE COMPANY TO DENY CLAIMS AND TO REFUND YOUR PREMIUM AS THOUGH YOUR CERTIFICATE HAS 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.

The above "Notice to Applicant" was delivered to me on:

Date

Applicant's Signature

AGENT CHECKLIST

By taking the time to check off the questions below, you are helping to ensure that your application has been filled out completely; allowing us to process the application quickly and accurately.

- | | |
|--|---|
| <input type="checkbox"/> Have you answered EVERY health question? (Make sure to check "Yes" or "No" for all sections of Question #15. If the answer is "Yes," please check all conditions that apply). | <input type="checkbox"/> Have you included payment or credit card information with the application? |
| <input type="checkbox"/> Is the physician information complete with name, address AND phone number? | <input type="checkbox"/> If the applicant is intending to replace current coverage have they signed the above Notice to Applicant Regarding Replacement of Health Insurance? |
| <input type="checkbox"/> Have you attached detailed descriptions for any health questions which have been answered "YES"? | <input type="checkbox"/> Have you completed the Conditional Receipt Form? |
| <input type="checkbox"/> Has the applicant signed AND dated the application? | <input type="checkbox"/> Have you separated and delivered the tear-off page (which includes the MIB, Inc. Pre-Notice, Investigative Consumer Report Notice, Abbreviated Notice of Information Practices, Conditional Receipt and Notice To Applicant Regarding Replacement of Health Insurance) to applicant? |
| <input type="checkbox"/> Have you filled out the Agent Information section, complete with your signature, agent number and current e-mail address? | |

Thank you for submitting your business to USL&H.

Did you know you can now submit applications electronically at www.unitedsecuritylandh.com?

Short Term Major Medical

The Perfect Solution if You Are:

- A Recent College Graduate
- Temporarily Unemployed
- A Temporary or Seasonal Worker
- Retiree Waiting for Medicare Coverage
- Waiting For Coverage from Your Employer
- Recently Discharged from the Military
- Applying for Major Medical Coverage with USL&H

Plan Highlights

- Coverage Available as Early as Next Day
- \$2 Million Lifetime Maximum
- Visit Any Doctor/Any Hospital
- Prescription Drug Coverage
- Limited Benefits While Outside the U.S.

Apply Online at www.unitedsecuritylandh.com and We'll Waive the \$25 Application Fee!

Other Health Care Products from United Security Life and Health

If you are approved for a Major Medical plan with USL&H, you may also be pre-approved for our ancillary products:

E-Z Life (Simplified-Issue)

Piece of mind for your final expenses

- Face Amounts from \$2,500 - \$25,000
- Whole Life Policy
- Simplified Underwriting – Only 7 health questions!
- Optional Accelerated Death Benefit

Disability Income

It works when you can't

- Monthly Benefits from \$400 - \$3,000
- 24-Hour Coverage – On or off the job!
- No Restrictions on How to Use Benefit Money

Cancer Benefit

Provides a benefit as soon as you need it... for whatever you need

- Guaranteed Renewable for Life
- Lump Sum Benefit up to \$50,000 Available
- Benefit Paid Upon Diagnosis - No restrictions on how you use the money!



www.unitedsecuritylandh.com

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