

**NEBRASKA 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

**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

**Preferred Value Plan**

High Deductible (HDHP)

**Deductible**

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

**Optional Benefits**

- Enhanced Prescription Drug Card

**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

**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 |
|---|---|

<b>Benefit</b>	<b>Benefit</b>
<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 non-refundable application fee 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
<b>1. Primary Insured</b> <input type="checkbox"/> <b>Uninsured Applicant</b>									<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>2. Spouse</b>									<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>3. Dependents</b>									Full Time Student <input type="checkbox"/> YES <input type="checkbox"/> NO
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](http://www.unitedsecuritylandh.com)?**



# Short Term Major Medical

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## 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](http://www.unitedsecuritylandh.com) and We'll Waive the \$25 Application Fee!

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## 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](http://www.unitedsecuritylandh.com)

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