



**FAMILY LIFE**  
INSURANCE COMPANY

A Member of the Manhattan Insurance Group

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**Secure Care**  
**HOSPITAL CONFINEMENT AND OTHER FIXED INDEMNITY**  
**INSURANCE POLICY**

Policy Forms Series FHCS11

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**AGENT'S GUIDE**

For Proper Underwriting and Rates  
Please check our Website for Current State Approvals

# Secure Care

## AGENT'S GUIDE

### GENERAL INFORMATION

This is not major medical insurance coverage. The plan only provides limited fixed indemnity benefits for hospital confinement and other specified medical Covered Events. A Covered Event is an observable and distinct occurrence in which medical treatment, services or supplies are provided to a Covered Person.

Fixed indemnity benefits are paid in the amount stated on the Benefit Schedule for the Covered Event regardless of the cost of services rendered. This plan does not provide expense reimbursement for charges based on the healthcare provider's statement. Policy Form is FHCS11 with state variability.

### CONDITIONALLY RENEWABLE

The Policyholder has the right to renew this Policy until attainment of age 65 if the correct premiums are paid when due or within the Grace Period. We retain the right to change the premium rates on this Policy. Premiums are based on the Policyholder's attained age. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all Covered Persons in the same class on the date of the change. Class is defined as attained age and underwriting class. If the Policyholder moves out of the state where this Policy is issued, We will replace this Policy with a similar fixed indemnity Policy with the form number this is issued in the Policyholder's new state of residence. The new Policy will be effective on the date the Policyholder becomes a resident of the new state. If the Policyholder moves to a state where We do not provide insurance under a fixed indemnity Policy with the same Policy design as this Policy, We reserve the right to terminate this Policy for the Policyholder and any Covered Dependents.

### PAYMENT OF BENEFITS

We will pay Scheduled Benefits only for the Covered Events listed in the Hospital Confinement and Other Fixed Indemnity Benefits section of Your Policy and any attached Riders. The Scheduled Benefit amount and the Maximum Benefit for eligible **Covered Events** listed in this section are shown in the Schedule of Benefits. Please refer to the exclusions section for occurrences for which benefits are not provided under this plan.

### COVERED EVENT

A medical Event for which this plan provides a Scheduled Benefit and that meets all of the following requirements:

1. A Health Care Practitioner, facility or supplier provides the treatment, services or supplies provided in connection with the Event.
2. A Covered Person incurs it while coverage is in force under this plan as specified in the Hospital Confinement and Other Fixed Indemnity Benefits section and the Benefit Schedule.
3. It is incurred for Events shown in the Benefits Section, any attached Riders and on the Schedule of Benefits. The occurrence includes treatment, services or supplies, which are Medically Necessary.

### BASE PLAN

**Inpatient Hospital Confinement Benefit:** We will pay the corresponding Scheduled Benefit amount for each day this is a charge for Inpatient room and board during a Confinement Period under the orders of a physician for care of a Sickness or an Injury. Benefits are limited to the Calendar Year Maximum Daily Hospital Confinement Benefit shown on the Schedule of Benefits.

**Emergency Room/Urgent Care Visits Benefits:** We will pay the corresponding Scheduled Benefit amount upon the occurrence of a visit to an Emergency Room or Urgent Care Facility during which a Covered Person received Emergency Treatment or Urgent Care. Benefits are limited to the Calendar Year Maximum Emergency Room/Urgent Care Benefit shown on the Schedule of Benefits.

**Hospital Admission Benefits:**

We will pay the corresponding Scheduled Benefit amount when a Covered Person is confined for the first time as a resident Inpatient during the Calendar Year. A maximum of one benefit per Covered Person per year is payable. Confinement as a resident Inpatient means assigned to a Hospital bed for an overnight stay for Medically Necessary reasons resulting from Injury or Sickness on the advice of a Health Care Practitioner.

**Professional Ground or Air Ambulance Services Benefits:**

We will pay the corresponding Scheduled Benefit when professional ground or air transportation in an ambulance is obtained by a Covered Person who needs Emergency Treatment, for a Sickness or an Injury. The ambulance service must meet all applicable state licensing requirements. Benefits are limited to the Calendar Year Maximum Benefit shown on the Schedule of Benefits.

**Surgical Services Benefits:**

We will pay the corresponding Scheduled Benefit when the Covered Person obtains surgical treatment as shown on the Surgical Schedule. Benefits are limited to the Calendar Year Maximum Benefit shown on the Schedule of Benefits.

**Anesthesia Benefits:**

We will pay an Anesthesia Benefit equal to 20% of the surgical benefit amount shown in the Surgical Schedule when a Covered Person is administered anesthesia as part of a surgery that is a Covered Event. Benefits are limited to the Calendar Year Maximum Benefit shown on the Schedule of Benefits.

**Assistant Surgeon Benefit:**

If an Assistant Surgeon is required to assist the Surgeon during the operation, We will pay a benefit equal to 20% of the benefit amount shown in the Surgical Schedule for the operation. Benefits are limited to the Calendar Year Maximum Benefit shown on the Schedule of Benefits.

**INTENSIVE CARE UNIT BENEFIT**

If a Covered Person is confined in a Hospital's Intensive Care Unit due to an Injury or Sickness, We will pay the Daily Benefit Amount shown on the Schedule of Benefits. We will pay this amount for each day of confinement for which there is a room and board charge by the Hospital; but not to exceed the Calendar Year Maximum as shown on the Schedule of Benefits.

**FIRST OCCURRENCE BENEFIT**

One First Occurrence Benefit is payable per Covered Person. If an event does not occur within the first 5 years this rider is in force, the First Occurrence Benefit will double. A benefit may be paid in one of two ways:

1. The First Occurrence Benefit listed in the Schedule of Benefits is payable if one of the following health events occurs for the first time in the Covered Person's lifetime and while this Rider is in force for the Covered Person.
  - Coma (non drug induced)
  - End Stage Renal Failure
  - Internal Cancer
  - Paralysis

2. A benefit equal to 50% of the First Occurrence Benefit listed in the Schedule of Benefits is payable if one of the following health events occurs for the first time in the Covered Person's lifetime and while this Rider is in force for the Covered Person.

- Coronary Artery Bypass Surgery
- Heart Attack
- Major Human Organ Transplant
- Stroke

The Company must be provided with a diagnosis by a Physician accompanied by documentation supported by clinical, radiological, histological and laboratory evidence satisfactory to the Company. The Company may, at its expense, require an examination or further tests by a Physician of its choice.

Once a benefit has been paid to a Covered Person, no additional benefits are payable to that Covered Person and their coverage under the rider will terminate.

#### **INTERNAL CANCER BENEFIT**

If a Covered Person receives a Positive Diagnosis of any type of Internal Cancer, We will pay the Monthly Benefit Amount shown on the Schedule of Benefits for this Rider. We will pay this amount each month beginning on the month the Covered Person receives such Positive Diagnosis and during the Covered Person's lifetime but not to exceed 6 months.

Once a benefit has been paid to a Covered Person, no additional benefits are payable to that Covered Person and their coverage under the rider will terminate.

#### **PRE-EXISTING CONDITION LIMITATION**

Pre-existing conditions may be excluded for 12 months following the effective date of coverage. A pre-existing condition is defined as a condition and related complications for which medical advice, diagnosis, care or treatment was sought, received or recommended from a provider, or Prescription Drugs were prescribed during the 12 month period immediately prior to the Covered Person's effective date of coverage under this Policy and any attached Riders, regardless of whether the condition was diagnosed, misdiagnosed or not diagnosed; or the condition produced symptoms which reasonably should have caused or would have caused an ordinarily prudent person to seek diagnosis, care or treatment.

Benefits are not paid for charges incurred due to a pre-existing condition until you have been continuously insured under the plan for 12 months. After the 12-month period, benefits are paid for a pre-existing condition, unless the condition is specifically excluded from coverage.

## **OPTIONAL RIDER BENEFITS:**

### **Out Patient Sickness & Injury Rider**

**Office Visit Benefits:** We will pay the corresponding Scheduled Benefit amount upon the occurrence of an Office Visit for a Covered Person during which any of the following professional services are rendered in a Health Care Practitioner's Office for a Sickness or an Injury:

- a. Measuring height, weight and blood pressure;
- b. Obtaining a health history;
- c. Performing a physical examination;
- d. Making a medical decision;
- e. Explaining treatment options;
- f. Developing a treatment plan; or
- g. Instructions for management of the condition.

Benefits are limited to the Calendar Year Maximum Office Visit Benefit shown on the Schedule of Benefits.

**Outpatient Medical Event Benefits:** We will pay the corresponding Scheduled Benefit amount upon occurrence of an Event wherein the Covered Person receives one of the following for treatment of a Sickness or Injury:

1. Covered Events involving Laboratory Services as shown on the Benefit Schedule that are incurred on an Outpatient basis.
2. Covered Events involving Radiology Services as shown on the Benefit Schedule that are incurred on an Outpatient basis.
3. Covered Events involving Physical Medical services as shown on the Benefit Schedule that are incurred on an Outpatient basis.

Benefits for are limited to the Calendar Year Maximum Outpatient Medical Event Benefit shown on the Schedule of Benefits.

**Allergy Shots and Immunization Benefits:** We will pay the corresponding Scheduled Benefit amount for each allergy shot received by a Covered Dependent child. We will also pay the corresponding Scheduled Benefit amount for each immunization received by a Covered Dependent child as recommended by the United States Preventive Service Task Force or the Advisory Committee on Immunization Practices on the date the immunization is rendered. If the administration of the shot or immunization occurs during an office visit, an Outpatient office visit is payable. Benefits are limited to the Calendar Year Maximum Allergy Shots and Immunizations Benefit shown on the Schedule of Benefits.

### **Prescription Drug Rider**

**Optional Outpatient Prescription Order Rider:** We will pay the corresponding Scheduled Benefit amount when a Covered Person fills a Prescription Order through an outpatient pharmacy. Refer to the Exclusions section for a description of what Prescription Order fill or re-fills are not eligible for benefits under this plan.

**This plan provides benefits only for Prescription Orders received on an Outpatient basis and comprised of:**

- a. Prescription Drugs that are fully approved and prescribed for the specified indications by the U.S. Food and Drug Administration (FDA) for marketing in the United States and can be obtained only with a Prescription Order from a Health Care Practitioner.

- b. Prescription Drugs in dosages, dosage forms, dosage regiments and duration of treatment that are Medically Necessary for the treatment of Sickness or Injury.
- c. Prescription Drugs that are within the quality, supply, or other limits that We determine is appropriate for a Prescription Drug.

If a Generic Prescription Drug is available and You receive a Brand Name Prescription Drug, only the Scheduled Benefit for the Generic Prescription Drug will be paid. We will not pay benefits for Prescription Order refills in excess of a number specified on the Health Care Practitioner’s Prescription Order or prescriptions refilled more frequently than the prescribed dosage indicates.

## Base Plan Benefits

### SECURE CARE BASE PLAN

SURGICAL AND HOSPITALIZATION BENEFITS	Inpatient Hospital Confinement Benefit	\$3,000 per day plus \$1,000 First Day Hospital Admission Benefit- One time per CY Limit of \$200,000 per calendar year for all inpatient confinements
	Intensive Care Benefit	\$600 additional Intensive Care Benefit limit of 10 days per CY
	Surgery Benefit	Includes surgical benefits for both inpatient and outpatient surgery paid at the scheduled benefit amount. \$50,000 CY Surgical Max
	Anesthesia Benefit	20% of the Surgical Benefit
	Assistant Surgeon Benefit	20% of the Surgical Benefit
	Ground and Air Ambulance Benefit	\$200 per ground transportation \$2,000 per air transportation -Limit of 2 one-way trips per calendar year for all ambulance transportation.
	ER or Urgent Care Benefit	\$300 ER or Urgent Care per CY
INTERNAL CANCER FIRST OCCURRENCE	Internal Cancer Benefit	Pays a monthly benefit of \$500 for six months for a positive diagnosis of any type of internal cancer.
	First Occurrence Benefit	\$5,000 for the first 5 years the policy is inforce for Internal Cancer, Coma, End Stage Renal Failure, or Paralysis. \$10,000 for policy years 6 and up.  Pays 50% of the above benefit for Coronary Artery Bi-Pass Surgery, Major Human Organ Transplant, Stroke, or Heart Attack

Lifetime Maximum	Maximum of \$2 million of Lifetime benefit
Medical Questions for Qualification	<ul style="list-style-type: none"> <li>• No Exams</li> <li>• Limited medical questions to qualify</li> </ul>
Pre-existing Conditions	Pre-existing conditions are covered for benefits after continuously insured under this plan for 12 months

**OPTIONAL RIDERS**  
**OUTPATIENT RIDER**

Doctor's Office Visit	<ul style="list-style-type: none"> <li>• \$50 per office visit</li> <li>• Provides 6 visits per calendar year</li> </ul>
Allergy Shots and Immunizations for Insured Children Only	<ul style="list-style-type: none"> <li>• \$20 per immunization</li> <li>• \$10 per allergy shot</li> <li>• \$100 per calendar year limit for all allergy shots and immunizations.</li> </ul>
Outpatient Medical Benefits	<p>Laboratory Services:</p> <ul style="list-style-type: none"> <li>• \$100 per surgical pathology test</li> <li>• \$25 per laboratory service, excluding surgical pathology</li> </ul> <p>Radiology Services:</p> <ul style="list-style-type: none"> <li>• \$100 per mammogram</li> <li>• \$250 per MRI scan</li> <li>• \$25 per other radiology services, including x-ray and ultrasound.</li> <li>• \$200 per CT scan</li> <li>• \$250 per PET scan.</li> <li>• \$25 per physical therapy, occupational therapy and speech therapy service.</li> <li>• \$1,500 per calendar year limit for all outpatient events.</li> </ul>

**PRESCRIPTION DRUG RIDER**

Rx Rider	<ul style="list-style-type: none"> <li>• \$10 generic</li> <li>• \$25 Name Brand</li> <li>• \$750 Calendar Year Maximum</li> </ul>
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**CONTINUITY OF COVERAGE**

Continuity of coverage does not apply to Limited-Benefit Fixed-Indemnity Plans.

**REPLACEMENT OF COVERAGE**

The replacement form is mandatory whenever replacement is involved.

### **ISSUE AGES AND PREMIUM AGES**

- The Insured and spouse must be between ages 18 through 64 to apply for individual coverage. Eligibility for coverage is determined by each adult age.
- Family Coverage is available for unmarried, dependent children under the age of 21(in NM and TX, age 25 regardless of student status). Unmarried children under the age of 25 may also be covered if enrolled as a full-time student in an accredited college or university. When the child reaches the limiting age, the child may “convert” to an individual policy without evidence of insurability, subject to the “Conversion” provision in the base policy.

### **COMPLETING THE APPLICATION**

- Use Application form# FHCSAPP11
- Be sure to ask the proposed insured’s ALL health questions and the answers recorded on the application exactly as stated to you.
- All applicants age 18 or older must sign the application.
- Always, take 60 seconds to recheck each application to make sure it is completed in its entirety and the premium calculated properly.
- Questions 1-19 must be answered by applicant.
- The agent statement has questions 1-4 that must be answered and signed by writing agent.
- Primary applicant will be designated by the oldest participant age.
- The applications can be faxed to 713-583-2738.

### **PLEASE MAIL APPLICATIONS TO:**

**FAMILY LIFE INSURANCE COMPANY  
ATTN: SECURE CARE DEPARTMENT  
10700 NW FREEWAY  
4<sup>TH</sup> FLOOR  
HOUSTON, TX 77092**

**PLEASE FAX APPLICATIONS TO 713-583-2738.**

**\* NOTE: PLEASE BE SURE TO INCLUDE A FAX TRANSMITTAL SHEET AND A COPY OF A VOIDED CHECK WITH EACH APPLICATION.**

# HOW TO COMPLETE THE SECURE CARE APPLICATION

PAGE 1

**FAMILY LIFE INSURANCE COMPANY**  
10700 Northwest Freeway  
Houston, Texas 77092

HOME OFFICE USE ONLY		
Pol. No. _____		
Pol. Date _____		
No. Units _____		

## HOSPITAL INDEMNITY APPLICATION

1. Print name of applicant and each member of the family

FIRST	MI	LAST	Social Security Number	Relationship	Sex	DOB	Age	Ht.	Wt. Now	Wt. 1 Yr Ago

**\*Please be sure to fill out the names, social security numbers, relationship to primary applicant, sex, date of birth, age, height, current weight and weight 1 year ago for each applicant.**

2. (a) Requested Coverage Effective Date \_\_\_\_\_  Individual  Individual and Spouse  One Parent Family  Two Parent Family  
 (b) Hospital Indemnity Plan: \_\_\_\_\_
- (c)  First Occurrence \_\_\_\_\_  ICU \_\_\_\_\_  Internal Cancer Benefit \_\_\_\_\_  
 Outpatient Rider \_\_\_\_\_  Prescription Drug Rider \_\_\_\_\_
3. (a) Method of Payment:  Bank Draft  Credit Card  Direct Bill  List Bill (b) Group # \_\_\_\_\_  
 (c) Premium Mode:  Annual  Quarterly  Semi-Annual  Monthly  Mode Premium \$ \_\_\_\_\_  
 (EFT/CC only)
4. Applicant's Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_
5. Business: Name (Applicant) \_\_\_\_\_ Occupation: \_\_\_\_\_
6. Business: Name (Spouse) \_\_\_\_\_ Occupation: \_\_\_\_\_
7. Mailing Address:  Business  Home \_\_\_\_\_
8. Mail Policy to:  Insured  Agent  Other \_\_\_\_\_
9. Do all the members to be insured reside in the home of the applicant?  YES  NO If "No" which member?  
 Explain: \_\_\_\_\_
10. Has any person proposed for insurance been declined for insurance due to health reasons?  YES  NO If yes, provide details and dates.  
 \_\_\_\_\_
11. Has any person proposed for insurance had surgery within the last 5 years?  YES  NO If yes, provide details (date, reasons, results)  
 \_\_\_\_\_
12. Has any person had surgery advised but not yet performed?  YES  NO If yes, provide details  
 \_\_\_\_\_
13. Has any person proposed for insurance been treated (including medication), within the last twelve months, by a physician for elevated blood pressure?  YES  NO If yes, please list the name(s) of the person (s), types on treatment including medication, date last seen by a physician, last blood pressure reading, and how long blood pressure has been under control and date diagnosed  
 \_\_\_\_\_
14. Have you or any person proposed for insurance within the past 5 years been diagnosed as having or been told by a doctor that they had or have any of the following conditions?  YES  NO If yes, circle the applicable conditions shown below. **If yes to any conditions, do not submit application.**

<p>a. Addison's Disease</p> <p>b. Acquired Immune Deficiency Syndrome (AIDS), or tested positive for antibodies to the Acquired Immune Deficiency Syndrome (AIDS) virus or Human Immunodeficiency Virus (HIV)</p> <p>c. Alcoholism &amp; Substance Abuse</p> <p>d. Cataracts uncorrected</p> <p>e. Cerebral Palsy</p> <p>f. Cirrhosis of the Liver</p> <p>g. Coronary Bypass</p>	<p>h. Currently (or within 3 months) hospitalized or confined to any health care institution</p> <p>i. Diabetes (except cases treated by diet alone)</p> <p>j. Functionally limiting musculoskeletal disease or disorder</p> <p>k. Grand Mal Epilepsy</p> <p>l. Heart Attack</p> <p>m. Hemophilia</p> <p>n. Hernia uncorrected</p> <p>o. Hepatitis (other than Virus A)</p> <p>p. Hodgkin's Disease</p>	<p>q. Internal Cancer within 10 years</p> <p>r. Leukemia</p> <p>s. Lung Disorder (Chronic)</p> <p>t. Mental or Nervous Disorder or disease or disorder of the Central Nervous System</p> <p>u. Multiple Sclerosis</p> <p>v. Paralysis</p> <p>w. Ulcerative Colitis</p> <p>x. Chronic Kidney Disease</p>
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FHCSAPP11

**Use Form #  
FH**

\*Please be sure to fill out the names, social security numbers, relationship to primary applicant, sex, date of birth, age, height, current weight and weight 1 year ago for each.

**\*Please be sure to answer  
ALL HEALTH QUESTIONS.**

# HOW TO COMPLETE THE SECURE CARE APPLICATION

## PAGE 2

15. To the best of my knowledge and belief, no person to be covered under the terms of this policy has now or during the past ten years has had cancer in any form including carcinoma in situ, except  NONE  \_\_\_\_\_ who is (are) to be excluded from coverage under this policy. CHECK ONE BOX.
16. I hereby represent that to the best of my knowledge, information and belief, no person to be insured under this policy is now or has ever been diagnosed or treated for (check condition):  NONE
- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Addison's disease            | <input type="checkbox"/> amyotrophic lateral sclerosis | <input type="checkbox"/> diphtheria          | <input type="checkbox"/> encephalitis         |
| <input type="checkbox"/> epilepsy                     | <input type="checkbox"/> legionnaires' disease         | <input type="checkbox"/> lupus erythematosus | <input type="checkbox"/> meningitis           |
| <input type="checkbox"/> multiple sclerosis           | <input type="checkbox"/> muscular dystrophy            | <input type="checkbox"/> myasthenia gravis   | <input type="checkbox"/> Niemann-Pick disease |
| <input type="checkbox"/> osteomyelitis                | <input type="checkbox"/> poliomyelitis                 | <input type="checkbox"/> Reye's syndrome     | <input type="checkbox"/> rheumatic fever      |
| <input type="checkbox"/> Rocky Mountain spotted fever | <input type="checkbox"/> sickle cell anemia            | <input type="checkbox"/> Tay-Sachs disease   | <input type="checkbox"/> tetanus              |
| <input type="checkbox"/> toxic epidermal necrolysis   | <input type="checkbox"/> toxic shock syndrome          | <input type="checkbox"/> tuberculosis        | <input type="checkbox"/> tularemia            |
| <input type="checkbox"/> typhoid fever                | <input type="checkbox"/> Whipple's disease             | <input type="checkbox"/> whooping cough      |   |
- State name(s) of who is (are) to be excluded from the dread disease condition checked. \_\_\_\_\_
17. I hereby represent that to the best of my knowledge, information and belief, within the last 6 months no person to be insured, has (1) undergone a biopsy, (2) had an elevated PSA (Prostate Specific Antigen) or (3) received medical advice or consultation or had medical tests advised or performed, including those during the course of routine check ups where the results were other than normal or still pending for cancer, except  NONE  \_\_\_\_\_ who is (are) to be excluded from coverage under this policy. CHECK ONE BOX
- 18.a. Are you, your spouse or anyone to be insured pregnant?  Yes  No If Yes, coverage cannot be issued under this Intensive Care Policy/Rider to any applicant.
- 18.b. Has any person to be insured ever received medical care for or been diagnosed with heart disease, heart surgery, any abnormalities of the heart, chest pain, heart attack, stroke, pacemaker implanted, blood vessel surgery, or been diagnosed or treated with high blood pressure unless controlled by diet and/or medication for at least one year?  Yes  No
18. c. If Yes, list the name(s) of persons: \_\_\_\_\_ Those persons will not be issued coverage under this Policy/Rider.
19. Will the insurance applied for replace existing insurance policy or contract in any company(s)?  Yes  No

**WARNING:** Any Person knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which is a crime.

I, the proposed insured(s), understand that the policy(s) issuance is based on all statements and answers indicated above, which are complete and true to the best of my knowledge. If any false statement or misrepresentation is made, the policy(s) attached after the policy effective date will not be effective until the effective date of the correction. If the false statement or misrepresentation is not corrected, the policy(s) will be void from the effective date stated in the rider(s). I understand that a false statement or misrepresentation under a policy or rider may result in a policy or rider being voided in any state where such a statement or misrepresentation is made.

I also represent that I have read, or had read to me, the policy(s) and rider(s) and understand the terms, conditions, exclusions, and limitations thereon which materially affects the insurance. I understand that a false statement or misrepresentation under a policy or rider may result in a policy or rider being voided in any state where such a statement or misrepresentation is made.

**QUESTIONS 1 – 19 MUST be answered by the APPLICANT.**

**AUTHORIZATION:** I hereby authorize any licensed physician, medical practitioner, pharmacy, or pharmacy related facility, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. (MIB), consumer reporting agency or employer, or other organization, institution or person having any record of me or any member of my family available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or a member of my family and any other non-medical information of me or a member of my family to give to Family Life Insurance Company, its reinsurers or its legal representative, or any medical or pharmaceutical records retrieval service Family Life Insurance Company may engage, any and all such information as permitted by law and the rules of MIB, Inc. I understand that I am authorizing Family Life Insurance Company to receive my health information, prescription drug usage history and my non-medical information. I understand that prescription drug usage may be used to verify the presence of certain medical conditions and that such history will not be used to decline coverage. These medical conditions will be confirmed by a telephone interview prior to being used in the underwriting process. I also authorize any consumer reporting agency to prepare or procure an investigative consumer report on me. I understand the information obtained by use of the Authorization will be used by Family Life Insurance Company to determine eligibility for insurance and/or eligibility for benefits under an existing policy. I agree that a photographic copy or a facsimile of this Authorization shall be as

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# HOW TO COMPLETE THE SECURE CARE APPLICATION

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valid as the original. I or my authorized representative is entitled to a copy twenty-four (24) months and may be revoked at any time. The revocation of this authorization includes any and all information you may have about diagnosis, testing, treatment, and prognosis of my physical or mental condition, treatment, psychiatric treatment, pharmacy prescriptions, Human Immunity and treatment, sickle cell testing and treatment, lab data, and EKGs. This company engaged by Family Life Insurance Company, including, but not limited to, require that we inform you of the potential that information disclosed by the recipient and no longer be protected by such regulation, all information this authorization will be protected by federal and state privacy laws and regulations. I understand that this authorization is required in order to enable Family Life Insurance Company to make underwriting and risk rating determinations, and underwriting and risk rating determinations relating to me and/or my minor children. If I refuse to sign or revoke this authorization, Family Life Insurance Company may refuse to consider my application for enrollment.

- ALL Applicants 18 or older must sign the application.
- Primary Applicant must sign and date the application.
- Primary applicant will be determined by the oldest participant's age.

DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

THE EFFECTIVE DATE OF THE POLICY WILL BE THE DATE RECORDED BY THE HOME OFFICE. IT IS NOT THE DATE THIS APPLICATION IS SIGNED. THE POLICY WILL BECOME EFFECTIVE WHEN ALL UNDERWRITING REQUIREMENTS HAVE BEEN SATISFIED.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_.

City State

X \_\_\_\_\_ X \_\_\_\_\_

Signature of Proposed Insured/Telephone Number Signature of Proposed Insured Spouse

### AGENT'S STATEMENT

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. Will the insurance applied for replace existing insurance policy or contract in any company(s)?      | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. If a replacement(s), and if state regulations require it, have you given the applicant:              |                          |                          |
| a. Notice to Applicant Regarding Replacement of Accident and Sickness Insurance?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Completed all replacements forms, if required in your state?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you complied with state regulations on disclosure?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. All information recorded by me on this application is true and accurate to the best of my knowledge. | <input type="checkbox"/> | <input type="checkbox"/> |

Agent No. \_\_\_\_\_ Soliciting Agent Signature \_\_\_\_\_ Date \_\_\_\_\_

( ) \_\_\_\_\_ Print Agent Name \_\_\_\_\_

Soliciting Agent Phone # \_\_\_\_\_

The AGENT'S STATEMENT has questions 1 – 4 that **MUST BE Answered and Signed** by the writing agent.

FHCSAPP11

HOW TO COMPLETE THE SECURE CARE APPLICATION

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For monthly payroll deduction enter list bill number if known.

For ( EFT), select a desired withdrawal date then print all info starting with the Bank Name.

BILLING

Monthly Payroll Deduction (list bill)

Assigned list bill number, if known: \_\_\_\_\_

Monthly Electronic Funds Transfer (EFT)/ Check-O-Matic

Select a desired withdrawal date 1-28: \_\_\_\_\_

Bank name: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Routing number: \_\_\_\_\_

Account number: \_\_\_\_\_



Authorization for Electronic Funds Transfer (EFT) / Check-O-Matic – please sign below

I (we) hereby authorize Family Life Insurance Company, hereinafter called COMPANY, to in \_\_\_\_\_ and  
depository, hereinafter called DEPOSITORY, to debit the same to such account.

This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or  
either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity  
to act on it.

Accountholder signature: \_\_\_\_\_ Date: \_\_\_\_\_

The account holder's signature and date are required for EFT.

Credit Card  Monthly  Quarterly  Semi-Annual  Annual or  
 Charge first payment only\*

\* You must also select a secondary billing method other than payroll deduction (list bill) for  
below, go to that section and complete.

Choose method:  Monthly Electronic Funds Transfer (EFT) / Check-O-Matic  
 Bill me directly

Credit cards are available for Monthly, Quarterly, Semi-Annual, Annual and 1<sup>st</sup> payment only billing Methods. If 1<sup>st</sup> payment only is selected, you must enter a secondary form of payment for future payments and fill out the box that corresponds to the secondary payment method.

Authorization for credit card payments – please sign below

I authorize Family Life Insurance Company to charge my account for the Hospital Ind  
there will be no refund of premium after the [10-30]-day free look in the contract.

Card number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Expiration date: \_\_\_\_ / \_\_\_\_

Card type:  MasterCard  VISA

Name as it appears on card: \_\_\_\_\_

Address of cardholder, if different \_\_\_\_\_

Cardholder signature: \_\_\_\_\_ Date: \_\_\_\_\_

If paying by Credit Card, please be sure to fill in card number, card type, expiration date, name as it appears on card and address of card holder. The cardholder MUST sign and date the application.

Bill me Directly:  Quarterly  Semi-Annual  Annual

If your billing address is different than your home address, please enter it here:

Billing Address: \_\_\_\_\_ (Street) \_\_\_\_\_ (City)

Name of person paying, if different: \_\_\_\_\_

Direct bill is only available for: Quarterly, Semi-Annual and Annual Billing Methods. If paying by Direct Bill, please be sure to include the billing address and name of person paying if different from the primary applicant.

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## UNDERWRITING

- Coverage is not guaranteed. Coverage may be declined based on medical history and/or eligibility criteria.
- The “Effective Date” of a policy will be the policy date stated on the policy schedule page. It is not the date the application is signed.
  - If an applicant is replacing any type of prior health insurance with a Health Access Limited-Benefit Fixed-Indemnity Plan, then they must complete the “Notice to Applicant Regarding Replacement of Accident and Sickness Insurance” Form.
  - Pre-existing conditions may be excluded for 12 months following the effective date of coverage. Benefits are not paid for charges incurred due to a pre-existing condition until continuously insured under the plan for 12 months. After the 12-month period, benefits are paid for a pre-existing condition, unless the condition is specifically excluded from coverage.
  - Persons under 19 years of age are subject to Pre-existing limitations under the Limited-Benefit Fixed-Indemnity Plans.

## ADULT BUILD CHARTS

Height				MALE	Height				FEMALE
F	I				F	I			
E	N				E	N			
E	C	Avg.			E	C	Avg.		
T	H	Weight	Decline		T	H	Weight	Decline	
5	0	129	209+		4	8	107	185+	
5	1	133	215+		4	9	110	190+	
5	2	138	224+		4	10	113	195+	
5	3	143	232+		4	11	115	199+	
5	4	147	238+		5	0	118	204+	
5	5	151	245+		5	1	121	209+	
5	6	156	253+		5	2	124	215+	
5	7	160	259+		5	3	128	221+	
5	8	165	267+		5	4	131	227+	
5	9	170	275+		5	5	134	232+	
5	10	174	282+		5	6	137	237+	
5	11	179	290+		5	7	141	244+	
6	0	184	298+		5	8	145	251+	
6	1	190	308+		5	9	150	260+	
6	2	195	316+		5	10	153	265+	
6	3	201	326+		5	11	159	275+	
6	4	206	334+		6	0	164	284+	
6	5	211	342+		6	1	168	291+	
6	6	217	352+		6	2	172	298+	
6	7	223	361+		6	3	176	304+	
6	8	228	369+		6	4	181	296+	

**CHILD**  
**JUEVENILE HEIGHT/WEIGHT CHART- MALE & FEMALE**

Age	MIN	MAX	Ages	MIN	MAX	Ages	MIN	MAX
0 – 2 Yrs.	LBS.	LBS.	3 – 9 Yrs.	LBS.	LBS.	10 – 14 Yrs.	LBS.	LBS.
20"	5	14	30"	18	40	48"	44	92
24"	8	23	34"	22	44	52"	54	108
26"	10	26	38"	26	54	56"	63	126
28"	13	31	42"	32	64	60"	74	144
30"	15	36	46"	38	78	64"	87	166
32"	18	40	50"	46	94	68"	100	186
34"	21	42	54"	56	111	66"	94	176
36"	23	45	58"	66	128	72"	113	206
38"	26	48				76"	126	228
40"	29	52						

Family Life Insurance Company Monthly Rates					
Insured	Benefit Package	Age Group			
		18-29	30-39	40-49	50-64
Individual	Base Plan	122.83	149.17	187.73	262.51
	RX Rider	11.23	13.52	16.49	21.15
	OP Rider	16.37	19.72	24.05	30.84
Individual & Spouse	Base Plan	245.65	298.34	375.45	525.02
	RX Rider	22.46	27.04	32.98	42.30
	OP Rider	32.74	39.44	48.10	61.68
Individual & Child(ren)	Base Plan	387.06	439.75	516.86	666.43
	RX Rider	27.95	30.24	33.21	37.87
	OP Rider	54.26	57.61	61.94	68.73
Family	Base Plan	418.48	471.17	548.28	697.85
	RX Rider	42.90	47.48	53.42	62.74
	OP Rider	79.05	85.75	94.41	107.99
Individual, Spouse, 1 Child	Base Plan	324.21	376.90	454.01	603.58
	RX Rider	31.75	36.33	42.27	51.59
	OP Rider	53.79	60.49	69.15	82.73

**MONTHLY BANK DRAFT, DIRECT BILL OR CREDIT CARD**

- In completing a bank draft form, please print all information starting with the name of the bank to be drafted as well as their city and state.
- Family Life requires a voided sample check along with a completed bank draft authorization form signed by the payor.
- The ABA transit number section is obtained from the upper right hand corner of the voided check. This information is usually on the date line of the voided sample check. Isn't this usually on lower right of ck?
- Under the account number section write the account number identically as it appears on the voided check. Do not include the check number.
  - Family Life accepts business on monthly bank draft, list bill and direct bill methods of payment. The annual, semiannual and quarterly modes of payment are acceptable for all forms of payment.
  - All premium checks must be payable to Family Life Insurance Company.
- Family Life does not accept:
  - post-dated checks;
  - C.O.D. applications;
  - partial payments;
  - applications with the date altered;
  - applications where “white-out” has been used;
  - personal checks from an agent or agency.