*NBAP*WNIC*ICI*

Application to: Washington National Insurance Company
11825 N. Pennsylvania St., Carmel, Indiana 46032-4555

SECTION I

Is this a reinstatement? Yes ☐ No ☐ Is this an upgrade of existing coverage? Yes ☐ No ☐
Is this a guaranteed conversion? Yes ☐ No ☐
If "Yes" to any of the above, provide existing policy number:_____
Requested Effective Date:_____

SECTION II

Please Print Primary Applicant's Name (First, Middle Initial, Last)				Height	Weight
(Applicant) ☐ Male ☐ Female	Date of Birth (mm/dd/yy)	Age	Social Security Number	(Area Code) Phone Number	
Spouse's Name(if applying for spouse insurance) (First, Middle Initial, Last)				Height	Weight
(Spouse) ☐ Male ☐ Female	Date of Birth (mm/dd/yy)	Age	Social Security Number	If applying for Child(ren) Insurance, complete Section IV.	
Applicant's Street Address					
City			State	Zip Code	
E-mail Address:					

SECTION III If you are applying through a guaranteed conversion, please answer only questions 1 and 2.

Please answer the questions below for the type of insurance being applied for:

For All Insurance Applied For:

1. Will this insurance replace any accident and sickness insurance currently in force with us or another company for any person to be insured? ..... ☐ Yes ☐ No
   If "Yes," please complete the "Notice to Applicant" form.

   For ages 65 and Over:

   a. Does this insurance duplicate any insurance you now have with any other company? ..... ☐ Yes ☐ No
      If "yes," complete the Duplication of Insurance form.

   b. Do you currently have a Medicaid eligibility card?..... ☐ Yes ☐ No
      If "yes," you are not eligible for insurance under this program.

2 Have you or anyone to be covered used any tobacco products in the past 10 years? .....
   Primary Applicant: ☐ Yes ☐ No
   Spouse: ☐ Yes ☐ No

3 In the past 10 years, have you or anyone proposed for coverage been treated for or diagnosed by a physician as having Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?..... ☐ Yes ☐ No
   If "Yes" to question 3, the named individual(s) is not eligible for coverage.
   Please list individual(s) name:_____
   _____

For Cancer Coverage.

4. Has any person proposed for coverage had within the past 5 years:
cancer or any malignancy which includes: carcinoma, sarcoma, Hodgkin's disease, leukemia, lymphoma, malignant tumor, cirrhosis, hepatitis B or C, blood disorder, emphysema, or chronic obstructive pulmonary disease (COPD)? ☐ Yes ☐ No

5. Within the last 5 years, has anyone to be covered been treated for or diagnosed as having a pre-leukemic condition, a pre-malignant condition or a condition with malignant potential? ☐ Yes ☐ No
If "Yes" to question 4 or 5, the named individual(s) is not eligible for coverage. Please list individual(s) name: _____

_____

For Heart Attack, Stroke, End-Stage Renal Failure Coverage.

6. Has any person proposed for coverage had within the past 5 years:
heart attack, heart disease, heart surgery, congestive heart failure, angina or prescribed nitroglycerin, any other abnormality of the heart including coronary artery disease, peripheral vascular disease, stroke, transient ischemic attack, or any other cerebrovascular disease, any abnormal kidney function, kidney disease, renal failure or insufficiency, required dialysis, diabetes, spina bifida, lupus, or sickle cell anemia? ☐ Yes ☐ No

7. Has any person proposed for coverage had a blood pressure reading in the last 6 months of greater than 150 systolic or 95 diastolic? ☐ Yes ☐ No
If "Yes" to question 6 or 7, the named individual(s) is not eligible for coverage. Please list individual(s) name: _____

_____

SECTION IV Dependent Child Coverage (Please Print and fill out completely)
(Each Child to be insured must meet policy eligibility requirements)

Name	Child(ren) Relationship to Primary Applicant	Date of Birth

☐ Check here if additional space is needed and attach separate sheet.

SECTION V

Coverage Selection:

☐ Critical Illness Cancer Only Coverage ☐ Critical Illness without Cancer Coverage ☐ Critical Illness with Cancer Coverage

Coverage Option: ☐ Option A ☐ Option B

Coverage Level:
☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000 ☐ $60,000 ☐ $70,000

Optional Rider:

☐ Cash Value *not available with Section 125

Payment Mode:	Premium Total:
Current Direct Bill Options: ☐ Monthly Bank Draft ☐ Semi-Annual ☐ Annual Current Payroll Bill Options: ☐ Payroll deduction ☐ Federal Allotment Payroll Deduction Frequency: ☐ 9 ☐ 10 ☐ 12 ☐ 13 ☐ 24 ☐ 26 ☐ 52 ☐ Section 125 Monthly Bank Draft is the only mode available on the following: ☐ Credit Union Account Number_____ ☐ Employee Non-payroll Account Number_____	Applicant Premium $_____ Spouse Premium $_____ Child(ren) Premium $_____ Optional Rider $_____ Total $_____ Amount Collected $_____ ☐ Draft initial premium payment (an "Authorization to Draft Initial Premium" form must be completed.) ☐ Check remitted with application *All checks should be payable to: Washington National Insurance Company

Special Instructions:

SECTION VI

Applicant's Statement: I have read or have had read to me, the completed application; all representations are true and complete. I understand that: any false statements or misrepresentations in this application may result in loss of insurance if such false statement materially affected either the acceptance of the risk or the hazard assumed by the Company. The agent has no authority to approve the application, change the policy or waive any policy provisions. For ages 65 and above, I have received the booklet containing insurance advice for people eligible for Medicare. Additionally, I acknowledge that I have received an Outline of Coverage. No coverage will be effective until all eligibility requirements are met and until the later of: (1) the Effective Date as shown on the Policy Schedule, if issued; or (2) the date the first premium is accepted by Washington National Insurance Company.

WARNING: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Date:_____ Signature of Applicant:_____

Where Signed:_____
(City, State)

This Section to be Completed by Agent: I hereby certify that I have explained to the applicant all exceptions and limitations pertaining to the insurance applied for, including any concerning pre-existing conditions. I hereby certify that I have truthfully and accurately recorded in this application the information supplied by the applicant. I further certify that I am a licensed agent in the state where this application is being solicited by me and signed by the applicant.

Date:_____ Signature of Agent:_____

Agency:_____ Agent Number:_____

Agent's E-mail address:_____

Agent's Phone Number:_____

☐ Mail to Policyholder ☐ Mail to Agent