REQUESTED EFFECTIVE DATE	**CONTINENTAL LIFE INSURANCE COMPANY of Brentwood, Tennessee** **APPLICATION FOR POLICY FORM HNF-97**	APPLICATION NUMBER

1. Print Full Name		Sex	Date of Birth Mo.	Day	Year	Age	Height Ft.	Ins.	Weight	Social Security #
A.	Applicant									- -
B.	Spouse									- -

2. Address _____ City _____ County _____
Street Address, Rural Route or Box Number
State _____ Zip _____ Phone # _____

3. If the answer to any of the following questions is "Yes," the Proposed Insured is not eligible for coverage:

		Yes	No
A.	Has any Proposed Insured been diagnosed and/or treated by a member of the medical profession for AIDS or AIDS Related Complex (ARC) or tested positive on an AIDS related test?	☐	☐
B.	Is any Proposed Insured covered under a State Medicaid program?	☐	☐
C.	Is any Proposed Insured currently hospitalized, bedridden, or confined to a wheelchair; using a walker, cane, oxygen or a dialysis machine; or been advised to have surgery completed and not done so?	☐	☐
D.	Does any Proposed Insured require assistance or supervision in performing any everyday activities such as walking, eating, dressing, toileting, shopping, bathing or housekeeping; or within the past year been confined to a nursing facility or received home health care?	☐	☐
E.	In the past 3 years, has any Proposed Insured received medical advice or consulted with a physician for any of the following conditions: internal cancer, leukemia, melanoma, kidney failure, amputation due to disease, stroke, transient ischemic attack (TIA), paralysis, cirrhosis of the liver, Parkinson's disease, organic brain or mental disease, senile dementia, Alzheimer's disease, Lou Gehrig's disease, muscular dystrophy, multiple sclerosis, uncontrolled diabetes, complications resulting from diabetes or requiring more than 50 units of insulin daily?	☐	☐

If a "Yes," answer is indicated above, to which Proposed Insured does it apply? ☐ A. ☐ B.

4. A. What other health insurance do you now have? List company name and policy number below. If none, so state. _____

B. Is this policy applied for intended to replace any insurance presently in force in this or any other company? ☐ Yes ☐ No
If the answer is "YES," list company name and policy number below and complete State Replacement Form, if applicable.

TYPE PLAN	COMPANY	TO BE REPLACED?	TYPE PLAN	COMPANY	TO BE REPLACED?
		☐ Yes ☐ No			☐ Yes ☐ No

5. I hereby apply to Continental Life Insurance Company of Brentwood, Tennessee for a policy to be issued solely and entirely in reliance on my written answers to the above questions. The answers are, to the best of my knowledge and belief, true. I agree the policy shall not be effective unless it has actually been issued. I have received an outline of coverage for the policy applied for and a Medicare Supplement Buyers Guide (if applicant 65 or over).

6. I, the undersigned Agent, certify: (1) I have accurately recorded the information supplied by the applicant; and (2) I have given an outline of coverage for the policy applied for and a Medicare Supplement Buyers Guide (if applicant 65 or over) to the Applicant.

7. (If applicant 65 or over) I understand that the policy applied for has benefits for hospital confinement indemnity that may possibly duplicate benefits received from Medicare; if so, benefits will be paid directly to me.

8. CAUTION: If your answers on this application are incorrect or untrue, the Company has the right to deny benefits or rescind your coverage.
I authorize any physician, hospital, clinic, character or credit source, insurance company, Medical Information Bureau, or other organization or person that has records or knowledge of me or my health, to give to any authorized representative of Continental Life Insurance Company of Brentwood, Tennessee or its reinsurers any and all information, medical or otherwise, about me. A copy of this Authorization shall be as valid as the original for thirty months.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

	AMOUNT	PREMIUM
Nursing Home Daily	$_____	$_____
Benefit Period ☐ 90 Day ☐ 180 Day ☐ 360 Day		
Elimination Period ☐ 0 Day ☐ 20 Day ☐ 100 Day		
Hospital Daily Amount	$_____	$_____
Policy Fee		$_____
TOTAL COLLECTED		$_____

MODE
☐ A
☐ SA
☐ Q
☐ BSP

Signed at _____ Date _____
(City and State)
Applicant **X** _____
Spouse **X** _____
Agent's Signature _____
Agent's Number _____
SEND POLICY TO: ☐ AGENT ☐ INSURED

NCR-APP-PA-001 LMK3267

Congratulations on your good judgement!

RECEIVED FROM _____ the sum of $_____ on _____, 20___
as payment on the first premium on a policy of insurance on each person proposed for insurance on this application subject to the conditions in this receipt. This receipt is conditioned on the answers to the questions on this application being true and correct. This receipt is subject to all terms, conditions and representations contained in the application and the respective coverage applied for. This receipt must not be detached from the application unless payment has been made at time of completing application.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY
DO NOT MAKE CHECK PAYABLE TO AGENT OR LEAVE THE PAYEE BLANK.

CONTINENTAL LIFE INSURANCE COMPANY
of Brentwood, Tennessee
101 Continental Place • Brentwood, Tennessee 37027
(615) 377-1300

_____
Agent's Signature

BANK SERVICE PLAN (BSP)

I request and authorize Continental Life Insurance Company of Brentwood, Tennessee to charge my bank checking account electronically, or by other commercially accepted method, for payment to the Company of premiums due under the policy. It is understood that the use of the Bank Draft Plan (herein referred to as "this Plan") does not change any policy provision.

The effective date of this Plan will be determined by the Company. In the event a charge is inadvertently not made, the Company may charge the account at a later date. Information as to each charge will be provided by entry on your bank statement or by other advice from the bank.

This plan may be terminated by the policyholder or by the Company upon 30 days written notice to the other party. In addition the Company may terminate this Plan if any charge is not paid upon presentation. If the Plan is terminated, premiums for the policy will be payable directly to the Company and will be determined on the basis of the Company's premium rates applicable to the policy.

SIGNATURE OF POLICYHOLDER: _____

DATE: _____

BANK NAME & ADDRESS: _____

_____

BANK TRANSIT NUMBER/ROUTING SYMBOL: _____

Important Notice to Agents: Attach voided copy of applicant's check.