Loyal American Life Insurance Company®
P. O. Box 559004 ●Austin, Texas 78755-9004 ●Toll Free Phone Number 1-800-633-6752
Enrollment Form for Cancer Expense Insurance and Optional Riders

ENROLLMENT FORM
SUBJECT TO UNDERWRITING

Employer			Group Number	Billing Mode ☐ M ☐ SM ☐ BW ☐ W ☐ Other	
Employee Proposed for Insurance (First, MI, Last)			S. S. Number		Employee Number
☐ Emp ☐ Spouse ☐ Child ☐ Other	☐ Male ☐ Female	Age	Birth Date	Home Phone Number	
Home Address			City	State	Zip
Job Title/Occupation	Do you normally work 20 or more hours per week for the Employer listed above? ☐ Yes ☐ No			State of Birth	Date Hired
☐ Payor or ☐ Owner (if other than Proposed Insured) & Address			S.S. Number or Tax ID Number		Birth Date

DEPENDENTS PROPOSED FOR INSURANCE

	Full Name	Sex		Birth Date
Spouse		☐ M	☐ F	
Children		☐ M	☐ F	
		☐ M	☐ F	
		☐ M	☐ F	
		☐ M	☐ F	
		☐ M	☐ F	
		☐ M	☐ F	
		☐ M	☐ F	

INSURANCE APPLIED FOR

Cancer Expense Insurance	Base Policy	ASCB	FOB	FOBB	RCIB required	SB	DHCB	SDB	ICUB	Modal Premium
☐ Individual	$	$	$	$	$	$	$	$	$	$
☐ One Parent					☐ Annual					
☐ Family					☐ Daily					
Section 125 ☐ Yes ☐ No							**TOTAL MODAL PREMIUM**			**$**

MEDICAL QUESTIONNAIRE

1.	Are you actively at work now for the named employer and have you worked at least 20 hours each week performing all duties of your regular occupation at your regular place of employment for the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy?	☐ Yes ☐ No
2.	Within the past five years, has any person proposed for coverage been diagnosed as having, been treated for or, had care for which diagnostic test(s) have been recommended for: Cancer, (including hodgkin's disease, lymphoma, leukemia, melanoma or any other malignancy) other than Skin Cancer? If "yes", list name of person(s) _____ **who is/are to be excluded from coverage.**	☐ Yes ☐ No
3.	Within the past three years, has any person proposed for insurance been diagnosed as having, been treated for or, had care for which diagnostic test(s) have been recommended for Skin Cancer? If "yes", name of person(s) _____ **who is/are to be excluded from coverage for cancer of the skin.**	☐ Yes ☐ No
4.	Has anyone proposed for coverage ever been diagnosed as having or treated by a member of the medical profession for: Acquired Immune Deficiency Syndrome (AIDS), "AIDS" Related Complex (ARC), or a condition or sickness derived from such infection, or tested positive for the Human Immuno-deficiency Virus (HIV) infection? If "Yes", list name of person(s) _____ **who is/are to be excluded from coverage**.	☐ Yes ☐ No

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MEDICAL QUESTIONNAIRE

If Optional Specified Disease Rider is Applied for, Answer this Question.		
5.	Within the past five years, has any person proposed for coverage been diagnosed as having, been treated for, or had care for which diagnostic test(s) have been recommended for: Addison's Disease; Amyotrophic Lateral Sclerosis; Botulism; Bovine Spongiform Encephalopathy; Budd-Chiari Syndrome; Cystic Fibrosis; Diptheria; Encephalitis; Epilepsy; Hansen's Disease; Histoplasmosis; Legionaire's Disease; Lupus Erythematosus; Lyme Disease; Malaria; Meningitis; Multiple Sclerosis; Muscular Dystrophy; Myasthenia Gravis; Nieman-Pick Disease; Osteomyelitis; Poliomyelitis; Q Fever; Rabies; Reye's Syndrome; Rheumatic Fever; Rocky Mountain Spotted Fever; Sickle Cell Anemia; Tay-Sachs Disease; Tetanus; Toxic Epidermal Necrolysis; Tuberculosis; Tularemia; Typhoid Fever; Undulant Fever; West Nile Virus; Whipple's Disease or Whooping Cough? If "yes", list name of person(s) and Specified Disease:_____ **who is/are to be excluded from coverage for the listed Specified Disease.**	☐ Yes ☐ No
If Optional Intensive Care Unit Rider is Applied for, Answer this Question.		
6.	Has any person to be insured ever been diagnosed or treated for a heart attack, heart condition, heart trouble, angina or any abnormality of the heart prior to this date? If "yes", name of person_____ **who is to be excluded from coverage for any intensive care confinement resulting from any disorder of the heart and shall be limited to three days in connection with any other intensive care confinement.** **The person(s) named above will be excluded from coverage as follows:** We will not be liable for any loss for Hospital Intensive Care Unit confinement resulting from any disease or disorder of the heart. Furthermore, the benefits for such person(s) for confinement in a Hospital Intensive Care Unit will be limited to three days in connection with any one hospitalization for all other sickness, not the 45 days as stated in the Rider. Nothing herein shall affect benefits for any covered Hospital Intensive Care Unit confinement resulting from an Injury.	☐ Yes ☐ No

NON-MEDICAL QUESTIONNAIRE

1.	Is any proposed insured eligible for Medicare? If "yes" review the Guide to Health Insurance for People with Medicare which is available from the company.	☐ Yes ☐ No
2.	Is any proposed insured eligible for Medicaid? **(If "Yes" applying for coverage on that person is not appropriate.)**	☐ Yes ☐ No
3.	**Existing Insurance**. Is any proposed insured covered under major medical insurance or an HMO? If "Yes", list name of proposed insured, coverage type, and insurance company.	☐ Yes ☐ No
4.	**Replacement.** Is the insurance applied for to replace or change any existing insurance? If "Yes" list coverage and name of company._____ and complete any required replacement form(s) provided by your agent and return with this application.	☐ Yes ☐ No

AGREEMENT: I have read or had read to me the completed enrollment form, and my statements and answers are true and complete, to the best of my knowledge and belief. I understand that any material misstatement or misrepresentation may result in loss of coverage. I understand that the effective date of the coverage will be the date stated on the Certificate's schedule page, not the date this enrollment form is signed. I understand that no agent can accept risks, modify policies, or waive any rights or requirements of Loyal American.

Signature of Applicant: X _____ **Date:** _____

Affidavit for Agent's Use Only: I hereby certify that I have truly recorded in this enrollment form the information supplied by the applicant. I also certify that the applicant has read or had read to him or her the completed enrollment form.

Licensed Resident Agent's Signature _____ Licensed Resident Agent's No. _____

Agent's Name: (please print) _____ State License No _____

Authorization and Request for Payroll Deductions

I have applied for Cancer insurance with Loyal American Life Insurance Company and I hereby authorize and request that you, my employer, deduct from my salary or wages the necessary amounts to pay the premiums for this insurance and forward it to Loyal American. If premiums for the insurance to which this authorization applies are part of a Cafeteria Plan, I understand that this authorization may not be revoked until the end of the Plan Year and only then by my written request. Otherwise, this authorization shall remain in effect until revoked in writing by me.

Per Pay Period Initial Premium Amount:$_____ Employer:_____

Employee Signature	Social Security or Employee Number	Date