Washington National Insurance Company

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

Policy Number to be Converted:

Applicant's Name *(Please Print: First, Middle Initial, Last)*	❑ Male ❑ Female	Date of Birth	Age	Social Security Number
Spouse's Name *(If Family Coverage)*	❑ Male ❑ Female	Date of Birth	Age	Phone Number ( )

Applicant's Address Number and Street City County State Zip Code

Children's Name(s) *(Must Meet Policy Definition Requirements)*

Employer's Name or Group/Association Name *(If Payroll Deduction)*	Section	Department #	Occupation

Please indicate below the type of insurance applied for and answer all applicable questions.

Has anyone to be insured under this policy:

- **ever had, been treated for, or been diagnosed as having: any heart disease; a heart condition; angina or a heart attack; any disorder; disease or abnormality of the coronary arteries; arteriosclerosis; chronic disease of the pericardium; diabetes; transient ischemic attack; stroke, whether or not resulting in paralysis?** ❑ **Yes** ❑ **No**
  If "yes," indicate name(s) of person(s), the disease or condition diagnosed or treated, medication prescribed and complete appropriate Exclusion Rider:_____
- **for any of the above conditions, within the last year, been advised by a medical practitioner to be hospitalized, or to have any diagnostic test or surgery which has not been completed?** ❑ **Yes** ❑ **No**
  If "yes," indicate name(s) of person(s) and complete appropriate Exclusion Rider:_____
- **ever had, been treated for, or diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?** ❑ **Yes** ❑ **No**
  If "yes," indicate name(s) of person(s) and complete appropriate Exclusion Rider:_____

Does this policy replace any insurance you now have with another company? ❑ **Yes** ❑ **No**

Type(s) of Insurance			**Mode of Payment**		**Premium Total**	
Heart (KH)	**First Occurrence Rider**	**Intensive Care (IS/IT)**			Heart	$_____
❑ Applicant Only ❑ Applicant & Children ❑ Applicant & Family	❑ $500 ❑ $1,000 ❑ _____	❑ Policy ❑ Rider ❑ Applicant Only ❑ Applicant & Family	❑ Payroll Deduction	❑ Monthly ❑ _____	First Occurrence	$_____
❑ Choice A ❑ Choice B: ❑ *Option 1* ❑ *Option 2* ❑ Choice C: ❑ *Option 1* ❑ *Option 2*	**Choose One:** ❑ Cash Value ❑ Benefit Builder ❑ None ❑ _____	**Base** ❑ 300 ❑ 550 ❑ _____ **Added Benefits** ❑ 100/50 ❑ 200/100 ❑ _____	❑ Federal Employee	❑ Bi-Weekly ❑ _____	Intensive Care	$_____
			❑ Employee/ Non-Payroll	❑ Monthly (Automatic Deduction) Complete authorization	_____	$_____
			❑ Association ❑ Direct	❑ Semi-Annual ❑ Annual	Total	$_____
					Amount Collected	$_____

Do you give Washington National Insurance Company permission to use your name only for marketing purposes? ❑ Yes ❑ No

Section 125 Plan: ❑ Yes ❑ No

Special Instructions

Applicant's Statement: I have read, or have had read to me, the completed application; the above representations are true to the best of my knowledge and belief. I understand that:

- any false statements or misrepresentations in this application may result in loss of insurance;
- the agent has no authority to approve the application, change the policy or waive any policy provisions;
- no insurance will be effective until the date stated in my policy and until all eligibility requirements are met; and,
- (for ages 65 and above) I have received the booklet containing insurance advice for people eligible for Medicare.

Authorization: I hereby authorize any legally licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person, that has any medical or non-medical record or knowledge of me, or any members of my family for whom application has been made, to give Washington National Insurance Company any such information. A photographic copy of this authorization shall be as valid as the original.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Date:_____ Signature of Applicant:_____ Signed In:_____
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 signed by the applicant.

Date:_____ Signature of Agent:_____ Agent #:_____ Agency:_____