

Section A: Applicant Information

Applying For: *(please check one)*

New Coverage, Reinstatement, Increase in Benefits

Primary Applicant

1. Last Name _____ First Name _____ MI _____
 Social Sec # _____ - ____ - _____ Sex _____ Age _____ Birth date ____ / ____ / _____

Spouse

2. Last Name _____ First Name _____ MI _____
 Social Sec # _____ - ____ - _____ Sex _____ Age _____ Birth date ____ / ____ / _____

Dependents

3. Last Name _____ First _____ MI _____ Sex ____ Age ____ Birth date ____ / ____ / _____
 4. Last Name _____ First _____ MI _____ Sex ____ Age ____ Birth date ____ / ____ / _____
 5. Last Name _____ First _____ MI _____ Sex ____ Age ____ Birth date ____ / ____ / _____
 6. Last Name _____ First _____ MI _____ Sex ____ Age ____ Birth date ____ / ____ / _____

(For additional dependents, please attach a separate piece of paper, signed by the applicant, including the above information for each dependent)

8. Street Address _____ City _____ ST _____ Zip Code _____
 9. Telephone (Day) _____ Telephone (Evening) _____

Section B: Coverage Selection and Premiums

Hospital Confinement Indemnity (U9910)

Coverage: *(check applicable)*

- Primary Applicant
- Spouse
- Dependent Children

Plan: *(check one)*

- Plan A
- Plan B
- Plan C
- Plan D
- Plan E

Modal Premium: \$ _____
 = Premium Due: \$ _____

Hospital Confinement & Home Care Indemnity - (U9911)
-Benefits Plus-

Coverage: *(check applicable)*

- Primary Applicant
- Spouse
- Dependent Children

Plan: *(check one)*

- Plan A
- Plan B
- Plan C
- Plan D
- Plan E
- Plan F
- Plan G

Modal Premium: \$ _____
 + Policy Fee \$ _____
 = Premium Due: \$ _____

First Diagnosis Cancer - (U0430)
-Cancer Plus-

Coverage: *(check applicable)*

- Primary Applicant
- Family

Scheduled Base Plan *(check one)*

- Option A
- Option B
- Option C
- Option D

Riders:

- Heart Attack and Stroke
- Return of Premium
- Lump Sum

\$ _____
 (\$1,000 - \$10,000)

Modal Premium: \$ _____
 + Policy Fee \$ _____
 = Premium Due: \$ _____

Premium Payment Modes: Monthly Bank Draft (.084) Quarterly (.265) Semi-Annual (.52) Annual

(If applying for Benefits Plus and Cancer Plus, only one Policy Fee is required)

Total Premium Collected: \$ _____

Section C: Medical / Underwriting Questions

10. Will the coverage(s) being applied for replace any existing hospital, medical, major medical, or hospital confinement indemnity insurance in this or any other company?..... YES NO
If yes, name of person this applies to _____ Company _____

Answer the following questions if applying for the Hospital Confinement Indemnity (U9910):

11. Does any person to be insured have any in force or applied for hospital confinement indemnity insurance? YES NO
Person(s) "YES" applies: _____ Amount of Coverage _____

Answer the following questions if applying for the Benefits Plus (U9911):

12. Has any person to be insured:
a. Been confined or advised by a doctor to be confined in a hospital or nursing facility within the past 30 days or been advised to have surgery and not done so?..... YES NO
b. In the past one year had internal cancer, Parkinson's disease, heart attack or heart surgery, Stroke or suffered from memory loss or received home health care?..... YES NO
13. Does any person to be insured require personal or mechanical assistance with any activities of daily living such as bathing, dressing, toileting, continence, eating or transferring or is wheelchair bound or bedridden?..... YES NO
14. Is any person to be insured covered under a state Medicaid program?..... YES NO
Person(s) "YES" applies: _____

If any part of question 12, 13, or 14 is answered "YES" that person does not qualify for the Benefits Plus plan

Answer the following questions if applying for the Cancer Plus (U0430) or Benefits Plus (U9911):

15. In the past 10 years has any person applying for coverage been diagnosed or treated for HIV or AIDS?... YES NO
Person(s) "YES" applies: _____
If question 15 is answered "YES" that person does not qualify for the Cancer Plus plan or Benefits Plus plan.

Answer the following questions if applying for the Cancer Plus (U0430):

16. In the past 10 years has any person to be insured had, been diagnosed as having, been advised to seek treatment for, received medication for, or been treated by a medical practitioner for:
a. Leukemia, Hodgkin's disease, malignant melanoma, sarcoma or any internal cancer, or had radiation or chemotherapy for any of these conditions?..... YES NO
b. Heart attack, heart bypass, or angioplasty, angina, stroke, or Transient Ischemic Attack (TIA)?..... YES NO
Person(s) "YES" applies: _____

If question 16a is answered "YES" that person does not qualify for the Cancer Plus plan

If question 16b is answered "YES" that person does not qualify for the Heart Attack or Stroke Rider

Section D: Authorization / Agreement

IN SOME STATES WE ARE REQUIRED TO ADVISE YOU OF THE FOLLOWING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false, incomplete, or deceptive statement of a material fact may be guilty of insurance fraud.

AUTHORIZATION: I (we) authorize United National Life Insurance Company of America (UNL) upon presentation of this Authorization, or a photocopy of it, the Company may obtain, without restriction (except psychotherapy notes), such information or records provided to any affiliate insurance company on previous applications and any information provided to our health division for underwriting or claim servicing purposes. This Authorization includes all information about drugs, alcoholism, and mental illness. I authorize all sources, except the Medical Information Bureau, Inc. to give such records to any agency employed by United National Life Insurance Company of America to collect such information. This authorization will be valid from the date signed for a period of two and on-half years. I agree a photographic copy of this authorization shall be as valid as the original. I have read this authorization and I have also received a copy of the Notice to Applicant, Parts 1 and 2 and the Description of Information Practices form prepared by United National Life Insurance Company of America (if required in your state).

I represent that the answers to the above questions are complete, true and correct to the best of my knowledge and belief. I understand that omissions, misrepresentations or misstatements could result in denial of an otherwise valid claim and/or rescission, voiding or reformation of insurance. I understand that no insurance will be effective until the effective date stated in my policy and until all eligibility requirements are met

X

Signature of Applicant

X

Signature of Applicant's Spouse (if applicable)

I certify that I have asked all the questions, and truly and accurately recorded the answers contained herein. To the best of my knowledge and belief, the insurance applied for: is or is likely, is not or is not likely to replace or change any existing policy(ies) or contract(s).

X

Soliciting Agent *Code No.* *Date* *Print Agent's Name*

MONTHLY PRE-AUTHORIZED PREMIUM PAYMENT PLAN

Authorization to Honor Withdrawals to be drawn by United National Life Insurance Company of America

TO _____
Name of my Bank My Bank's Address City State Zip Code

As a convenience to me, I request and authorize you to charge the account shown below for premiums drawn by and payable to the order of United National Life Insurance Company of America, Glenview, Illinois, provided there are sufficient funds in my account to pay the same upon presentation.

Account #: _____ Bank Routing #: _____

Account Type: Checking Account (*Attach a Voided "Sample" check*) Savings Account (*Attach a Voided "Sample" check if applicable, or a Deposit slip*)

I agree that my rights in respect to each payment shall be the same as if it were drawn by me and signed personally by me. This authority is to remain in effect until revoked by me in writing and until you receive notice for which you agree you will be fully protected in honoring such requests. I further agree that if any such payment is not honored, whether with or without cause and whether intentionally, or inadvertently, you shall be under no liability at all although such action could result in the forfeiture of insurance.
