Insured by Humana Insurance Company

Term Life Insurance Application

TEXAS

Please print clearly in ink and answer all questions or indicate "not applicable."

Primary Applicant Information

Last name | First name | M.I. | Gender

Address | City | State | Zip Code | Height | Weight

Birth Date | Country/State of Birth | Social Security Number

Home Phone Number ( ) | Daytime Phone Number ( ) | Driver's License Number

Occupation

Email address

Policyowner information if other than Primary Applicant | Home Phone Number ( ) | Daytime Phone Number ( )

Address | City | State | Zip Code

The amount of term life insurance I want is______________. (Minimum selection is $25,000)
If you are applying for more than $150,000 of coverage, please provide your annual income:___________
Term length: ☐ 10 years ☐ 15 years ☐ 20 years

Primary Beneficiary | Relationship

Secondary Beneficiary | Relationship

Additional Benefits: ☐ **Accidental Death:** Provides accidental death benefit that is equal to the coverage amount________________
☐ **Children's Term Insurance:** Provides a $5,000 death benefit for each of your children who are age 30 days to 19 years.
☐ **Waiver of Premium:** Provides premium payment in the event of your total disability before age 60.

Do you or any of your dependents have any life insurance and/or annuity coverage currently in force? ☐ NO ☐ YES

Will the insurance coverage applied for be used to replace any existing life and/or annuity coverage? ☐ NO ☐ YES If yes:
Company Name | Amount | Policy Number

ANSWER THE FOLLOWING QUESTIONS FOR YOURSELF AND DEPENDENT CHILDREN IF APPLYING FOR COVERAGE

	Yes	No
1. Are you currently working or are you capable of working outside the home for 20 hours per week or more?	☐	☐
2. Have you ever been diagnosed by a physician as having acquired immunodeficiency syndrome (AIDS) or AIDS related complex?	☐	☐
3. Have you ever used illegal drugs, or received counseling or been advised to seek counseling for alcohol or illegal drug use?	☐	☐
4. In the past 12 months have you used any products that contain tobacco?	☐	☐
For the following questions, please provide specific details to any "Yes" answers and attach to the application.		
5. At this time, do you have a planned surgery scheduled, or been advised by a physician to undergo surgery for any reason?	☐	☐
6. In the past 2 years, have you been hospitalized for two or more consecutive days?	☐	☐
7. In the past 2 years, have you consulted a physician other than for a common cold, flu, or routine physical exams?	☐	☐
8. In the past 2 years, have you taken or been advised to take any prescribed medications?	☐	☐
9. In the past 5 years, have you engaged in or do you plan to engage in sky diving, private aviation, hang gliding, rock climbing, ballooning, bungee jumping, parachuting, or motorized racing?	☐	☐
10. In the past 5 years, have you been convicted of driving under the influence of drugs or alcohol?	☐	☐
11. In the past 5 years, have you been declined or rated for life, health, or disability insurance?	☐	☐
12. In the past 5 years, have you had your driver's license suspended or revoked, or have you ever been convicted of any felony?	☐	☐
13. In the past 10 years, have you been diagnosed with, treated for, or told by a medical professional that you have had any of the following (please circle if yes):	☐	☐

a. blood or lymph node disorder; b. cancer or tumor; c. chest pain; d. diabetes; e. epilepsy; f. gastrointestinal disorder; g. heart or circulatory disorder; h. hepatitis or liver disorder; i. high blood pressure; j. kidney disorder; k. lung or respiratory disorder; l. mental or nervous disorder including Huntington's Chorea or A.L.S.; m. spine disorder; n. stroke; or o. systemic disease (e.g. lupus, MS, scleroderma, etc.)

Initial Payment Options

Initial payment must total one month's premium for each product selected. Agent/Producer payments are not accepted. Please choose your preference for payment of 1st months premium.

☐ Credit or Debit Card ☐ One time bank withdrawal

Subsequent Payment Options

Please indicate both billing preference and payment method.

☐ Monthly Billing:	☐ Quarterly Billing:	☐ Semi-Annual Billing:	☐ Annual Billing:
☐ Automatic bank withdrawal ☐ Credit Card ☐ Debit Card	☐ Automatic bank withdrawal ☐ Credit Card ☐ Debit Card	☐ Automatic bank withdrawal ☐ Credit Card ☐ Debit Card ☐ Direct Bill	☐ Automatic bank withdrawal ☐ Credit Card ☐ Debit Card ☐ Direct Bill

Please complete automatic bank withdrawal information, credit or debit card authorization section.

Automatic Bank Withdrawal

☐ I authorize Humana Insurance Company to draw premium payment from account #_______________ until this authorization is revoked by me.

Account Holder's Name *(please print)* Relationship to Applicant(s)

Bank Name Address

Phone Number Routing Number

Credit or Debit Card option

☐ Credit Card ☐ Visa
☐ Debit Card ☐ Mastercard

☐ I authorize Humana Insurance Company to bill my VISA/Mastercard account for the initial payment. Authorized Amount: $________________

Card No.: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Expiration Date (MO/YR): ☐☐ / ☐☐

Cardholder's Name:

Agreement and Signature

True and Complete Acknowledgment:

I understand, agree and represent:

- I have read this document or it has been read to me.
- The answers are, to the best of my knowledge and belief, true and complete.
- I have received and reviewed a proposal and any state required disclosures.
- Neither I nor my agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of the Company's other rights and requirements.
- If this application for coverage is accepted, coverage will be effective on the date specified by the Company on the Policy. Acceptance of premium and fees does not guarantee coverage.
- To automatic withdrawal from my specified bank account for premium payment and administrative fees if selected under the product section.
- Premiums already paid will be refunded to me if a policy is not issued.
- Only individuals who meet the eligibility and underwriting requirements are eligible to maintain coverage.
- Any misrepresentation of material fact or omission contained herein relied on by the Company may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation of material fact or omission affects the acceptance of the risk.

This document, together with any supplements, will form part of any contract and be the basis for any Policy issued.

Authorization

My dependents and I authorize any physician, medical or health care practitioner, hospital, clinic, other medical or medically-related facility, third party administrator, Pharmacy Benefit Manager, insurance, HMO or reinsuring company, the Medical Information Bureau, Inc., employer or the Consumer Reporting Agency having information regarding myself and my dependents, including information concerning, advice, diagnosis, treatment and care of the physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse, illness and copies all hospital or medical records, non-public personal health information, to share with the Company, its reinsurer, or its legal representatives, and its affiliates, any and all such information.

My dependents and I understand and agree:

- The information obtained by use of this authorization may be used by the Company to determine eligibility for coverage, eligibility for benefits under an existing policy, plan administration, and make claim determinations.
- Any information obtained will not be released by the Company to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing health care operations or business or legal services in connection with any application, claim or as may be otherwise lawfully required, or as we may further authorize. I (we) may request to be interviewed in connection with the preparation of the report and I (we) may request a copy of the report.
- We may request to receive a copy of this authorization.
- A photographic copy of this authorization shall be as valid as the original.
- This authorization shall be valid for two years from the date shown below.

Any person who submits an application containing a false, incomplete or deceptive statement may be guilty of insurance fraud.

Applicant's Signature: X____ Date________________

Payor's Signature: X____ Date________________
(if other than insured)