CUL FirstChoice
APPLICATION CHECKLIST

Please complete this page and the application in its' entirety and Fax/ mail/ e-mail to All American Brokers

Sample Only - Not for Public Use

Agent:_____ **Date:**_____

Proposed Insured:_____

Plan Selected:_____ **Monthly Premium:**_____

Effective Date:_____ **Agent Phone:**_____

All American Brokers
6162 E. Mockingbird Ln.
Suite 104
Dallas, Texas 75214
Phone: 800-462-2322
Fax: 214-821-6676
E-mail: info@allamericanbrokers.com

CENTRAL UNITED LIFE INSURANCE COMPANY **Application for Insurance**

FRAUD: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which is a crime.

☐ Check if replacing or changing existing coverage in this company. **Policy Number** _____

PERSONS PROPOSED FOR INSURANCE								
Last Name	First	Middle	Relationship	Birthdate	Sex	Height	Weight	Social Security Number
			Primary Insured	/ /				
			Spouse	/ /				
			Child	/ /				
			Child	/ /				
			Child	/ /				

Address	City	State	Zip	Home Telephone ( )
Secondary Address	City	State	Zip	Home Telephone ( )

Payor or Owner if other than Primary Insured	☐ Payor ☐ Owner	Social Security No. - -	Relationship to Primary Insured
Employer	Date Employed	Occupation	

Hours Worked/Week	Monthly Income $	Group Number	Employee/Payroll Number
Beneficiary (Estate of Primary Insured unless beneficiary named)		Age	Relationship

FOR THE PAST 30 DAYS: Have all proposed Insureds been performing normal activities and been actively at work full time at their regular occupation? _____ Yes _____ No. If "No", explain: _____

WILL THIS POLICY REPLACE OR CHANGE ANY: Existing Life or Health Insurance in this or any other company? _____ Yes _____ No.
If "Yes", complete replacement form where required.

INSURANCE PLANS								Monthly Premium
HOSPITAL	Base Policy	AD & D Rider	Emergency Acc. Rider	Hospital Injury Rider	ICU Rider	Lump Sum Rider	Outpatient Sick.Rider	
☐ 0/0 180 Primary Ins.	$ _____	$ _____	$ _____	$ _____	$ _____	$ _____	$ _____	
☐ 0/0 365 Spouse	$ _____	$ _____	$ _____	$ _____	$ _____	$ _____	$ _____	
☐ 0/3 365 Children	$ _____	$ _____	$ _____	$ _____	$ _____	$ _____	$ _____	
	Private Nurse Rider	Surgical Rider	Surgical + Rider	Spec. Injury Rider	1st Hospital Conf. Rider	_____	_____	
Primary Insured	$ _____	$ _____	$ _____	☐	☐	$ _____	$ _____	
Spouse	$ _____	$ _____	$ _____	☐	☐	$ _____	$ _____	
Children	$ _____	$ _____	$ _____	☐	☐	$ _____	$ _____	$ _____

If Guaranteed Issues requirements are met, medical underwriting will be waived.

1. **HAS ANY PROPOSED INSURED:** Ever been treated for or been told by a member of the medical profession that he/she had Acquired Immune Deficiency Syndrome (AIDS) and/or tested positive for HIV (Human Immunodeficiency Virus)? _____ Yes _____No
2. **HAS ANY PROPOSED INSURED:** Consulted a Physician, received medical treatment of any kind, or been hospitalized or confined during the past 4 years? _____ Yes _____ No
3. **IS ANY PROPOSED INSURED** currently covered or eligible for Medicare? _____ Yes _____ No. If Yes, a "Guide to Health Insurance for People with Medicare" must be given to any proposed Insured age 65 or over.

Details of "Yes" answers in 1 or 2 above. Attach additional sheet if necessary.

Question No.	Name	Date	Type of Injury/Illness	Doctor/Hospital & Address	Fully Recovered?	Medication Taken

Authorization to Obtain and Release Information: I hereby AUTHORIZE any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. (MIB) consumer reporting agency or employer, or other organization, institution or person having any record of me or any member of my family available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or a member of my family and any other non-medical information of me or a member of my family to give to Central United Life Insurance Company, its reinsurers or its legal representative, any and all such information as permitted by law and the rules of MIB, Inc. I also authorize any consumer reporting agency to prepare or procure an investigative consumer report on me. I understand the information obtained by use of the Authorization will be used by Central United Life Insurance Company to determine eligibility for insurance and/or eligibility for benefits under an existing policy. I AGREE that all answers given in this application are complete and true to the best of my knowledge and belief, and that this application is to be attached to and made a part of the policy. I AGREE that a photographic copy of this Authorization shall be as valid as the original. I or my authorized representative is entitled to a copy of this Authorization. This Authorization will remain valid for twenty-four (24) months and may be revoked at any time. The revocation of the authorization must be submitted in writing. I ACKNOWLEDGE receipt of the Notice of Information Practices and the Medical Information Bureau Disclosure Notice.

I agree and understand that no insurance coverage will be in force until the effective date specified by the Company. No Agent or Broker is authorized to make or modify any policy or waive any of Central United's rights or requirements or waive the answer to any question in the application. No change to the policy will be valid until approved by an Officer of the Company which must be noted on or attached to the policy. The policy with this application and any endorsements, riders or other papers, if any, is the entire contract of insurance. I hereby apply for insurance coverage to be issued solely and entirely in reliance upon the written answers to the foregoing questions and/or information obtained by the Company in its underwriting process. I and my agent certify that I have read or had read to me all the questions and answers in this completed application and such answers to the best of my (our) knowledge and belief are true and complete. I understand and agree that the falsity of any answer or statement in this application which materially affects the acceptance of the risk or hazard assumed by the Company may bar the right to any recovery under any policy(s) issued contracts, waive any Company rights or requirements or waive any information the Company requests.

AGENT'S STATEMENT: I, the undersigned agent, also certify that to the best of my knowledge, replacement ☐ is ☐ is not involved at this time.

Signed at _____ this _____ day of _____ 20 _____
City, State

X _____ X _____ X _____
Signature of Primary Insured (Parent if person to be insured is less than 15 years old) | Payor/Owner (if other than Proposed Insured) | Spouse

X _____ _____ _____ _____ % _____
Signature of Agent | Agent's Name (printed) | Agent No. | % Credit | State ID No.

NOTICE: ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO CENTRAL UNITED LIFE INSURANCE COMPANY. DO NOT MAKE THE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

CUL-HPHI-APP-2010

PREMIUM DEDUCTION AUTHORIZATION TO THE EMPLOYER

You are hereby authorized to deduct $ _____ from my pay according to the deduction mode indicated below, until further notice from me, and remit to Central United Life Insurance Company [10700 Northwest Freeway, Houston, Texas 77092].

Premiums will be deducted ☐ Weekly ☐ Monthly ☐ Bi-Monthly ☐ Other Specify _____

Name _____ Date _____

Employee's Signature _____ Agent's Signature _____

BANK DRAFT AUTHORIZATION TO HONOR CHECKS DRAWN BY CENTRAL UNITED LIFE INSURANCE COMPANY

To _____

Your Bank's Address _____

As a convenience to me, I hereby request and authorize you to pay and charge my account checks drawn on my account by and payable to the order of Central United Life Insurance Company of [Houston, Texas] provided there are sufficient funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually received such notice I agree that you shall be fully protected in honoring such check. I further agree that if any such checks be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Date _____ X _____
Your signature Exactly as it appears on Bank Records Account No.

To obtain further information, contact
Central United Life Insurance Company

Notice of Information Practices
Including Fair Credit Reporting Act Notice and MIB, Inc. Notice

Thank you for your application. It is the major source of information about you which we use in evaluating your application and reviewing your policy. However, we wish to inform you that an investigative consumer report may be ordered as to your insurability. If an investigative consumer report is prepared in connection with this application, you may request to be interviewed in connection with the preparation of this report. This report may include, if applicable, information as to your character, general reputation, personal characteristics and mode of living as may be obtained through interviews with family members, friends, neighbors and associates. If you would like to know whether such a report was ordered and, if so, receive additional information as to its nature and scope, including the name, address and phone number of the reporting agency, we will be pleased to furnish this information upon your written request to our Home Office at the above address. You may receive a copy of such report by contacting the reporting agency.

Our experience shows that information from investigative reports usually does not have any adverse effect on our underwriting decision. However, if it should, we will notify you in writing of this fact as well as provide you the identity by name and address of the reporting agency. You may then wish to discuss the matter with that agency. We will not disclose information about you without your prior written authorization except as permitted by law. In certain situations we may disclose, as allowed by law, all types of nonpublic personal information as is necessary in order to conduct our business.

This could include disclosures to persons or organizations that will use the information for sales purposes, unless you indicant to us that you do not want the information disclosed for this purpose. You have the right to obtain access to certain items of information we have collected about you, and you have the further right to request correction of information if you feel it is inaccurate. If you wish to have a more detailed description of our information practices, we will be pleased to furnish this information upon your written request to our Home Office at the address on the front of this Notice..

MIB, Inc. Notice

While the information regarding your insurability is treated as confidential, Central United Life Insurance Company or its reinsurers may make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. Should you apply for life or health insurance, or submit a claim for benefits to another member company, the Medical Information Bureau, upon request from that member company, will supply the information in its file. Upon written request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's Information Office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone number (781) 751-6000. We or our reinsurers may also release information in our file to other life insurance companies to whom you apply for life or health insurance or to whom a claim for benefits may be submitted.

THE MANHATTAN LIFE
INSURANCE COMPANY

Underwriting Authorization

Name(s) of Proposed Insureds

Applicant's Social Security Number: _____

Applicant: _____* Spouse: _____

Dependant: _____ Dependent: _____

Dependant: _____ Dependent: _____

*If you are requesting coverage as a representative for any minor individual on this application and are not the parent or legal guardian, you must attach documentary evidence of your authority to act as the individual's representative for this authorization to be valid.

I hereby authorize any licensed physician, medical practitioner, pharmacy, or pharmacy related facility, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. (MIB), consumer reporting agency or employer, or other organization, institution or person having any record of me or any member of my family available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or a member of my family and any other non-medical information of me or a member of my family to give to Manhattan Life Insurance Company, it's reinsurers or its legal representative, or any medical or pharmaceutical records retrieval service Central United Life Insurance Company may engage, any and all such information as permitted by law and the rules of MIB, Inc. I also authorize any consumer reporting agency to prepare or procure an investigative consumer report on me. I understand the information obtained by use of the Authorization will be used by Manhattan Life Insurance Company to determine eligibility for insurance and/or eligibility for benefits under an existing policy. I agree that a photographic copy or a facsimile of this Authorization shall be as valid as the original. I or my authorized representative is entitled to a copy of the authorization. This authorization will remain valid for twenty-four (24) months and may be revoked at any time. The revocation of the authorization must be submitted in writing.

This authorization includes any and all information you may have about me, including, but not limited to information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, lab data, and EKGs. This information may also be disclosed to any medical records company engaged by Manhattan Life Insurance Company, including, but not limited to MIB, Inc. and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Manhattan Life Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations.

I understand that this authorization is required in order to enable Manhattan Life Insurance Company to make eligibility, enrollment, benefit determinations, and underwriting and risk rating determinations relating to me and/or my minor children. If I refuse to sign or revoke this authorization, Manhattan Life Insurance Company may refuse to consider my application for enrollment.

SIGNATURES

_____ Applicant	_____ Spouse
_____ Dependent	_____ Dependent
_____ Dependent	_____ Dependent

PLEASE RETAIN A COPY FOR YOUR RECORDS

MANHATTAN INSURANCE GROUP

CENTRAL UNITED LIFE
INSURANCE COMPANY

Underwriting Authorization

Name(s) of Proposed Insureds
Applicant's Social Security Number: _____
Applicant: _____* Spouse: _____
Dependant: _____ Dependent: _____
Dependant: _____ Dependent: _____
*If you are requesting coverage as a representative for any minor individual on this application and are not the parent or legal guardian, you must attach documentary evidence of your authority to act as the individual's representative for this authorization to be valid.

I hereby authorize any licensed physician, medical practitioner, pharmacy, or pharmacy related facility, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. (MIB), consumer reporting agency or employer, or other organization, institution or person having any record of me or any member of my family available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or a member of my family and any other non-medical information of me or a member of my family to give to Central United Life Insurance Company, it's reinsurers or its legal representative, or any medical or pharmaceutical records retrieval service Central United Life Insurance Company may engage, any and all such information as permitted by law and the rules of MIB, Inc. I also authorize any consumer reporting agency to prepare or procure an investigative consumer report on me. I understand the information obtained by use of the Authorization will be used by Central United Life Insurance Company to determine eligibility for insurance and/or eligibility for benefits under an existing policy. I agree that a photographic copy or a facsimile of this Authorization shall be as valid as the original. I or my authorized representative is entitled to a copy of the authorization. This authorization will remain valid for twenty-four (24) months and may be revoked at any time. The revocation of the authorization must be submitted in writing.

This authorization includes any and all information you may have about me, including, but not limited to information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, lab data, and EKGs. This information may also be disclosed to any medical records company engaged by Central United Life Insurance Company, including, but not limited to MIB, Inc. and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Central United Life Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations.

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SIGNATURES	
_____ Applicant	_____ Spouse
_____ Dependent	_____ Dependent
_____ Dependent	_____ Dependent

PLEASE RETAIN A COPY FOR YOUR RECORDS

MANHATTAN INSURANCE GROUP

Consumer Understanding Section

Applicant's Name _____

Applicant's Signature_____ **Agent's Name** _____

1) The above referenced agent visited with me in reference to making an application for insurance with your company. The soliciting agent explained to me the provisions showing benefits, waiting periods, limitations, and exclusions. I have received an outline of coverage for the policy(s) for which I applied. I understand that I must be working an average of 30 hours per week in order to qualify for **Guaranteed Issue** consideration with any **FirstChoice** plan design. **Applicant's Initials** _____

2) I understand that CUL Hospital Indemnity policies are limited benefit policies, and the policy(s) I am purchasing have limited outpatient coverage and doctor benefits. I know that this policy(s) will not cover everything, and that I will be responsible for some costs. **Applicant's Initials** _____

3) I understand that I will not have insurance coverage with CUL until my application(s) has been approved and the Company has notified me that I have been accepted for coverage with a particular effective date.

Applicant's Initials _____

4) I understand that even though I may be accepted for coverage I may have exclusionary riders for particular pre-existing medical conditions, and that conditions for which I have sought or received treatment or manifest symptoms in the 12 months prior to my application date will not be covered until 12 months after my policy effective date if fully disclosed, and that I should not let any other coverage lapse until I have received and reviewed the FirstChoice individual policy(s) in my name and found them to be suitable for my needs.

Applicant's Initials _____

5) I understand that the **CUL CP4000 Cancer Plan is NOT Guaranteed Issue,** and must be applied for and be underwritten separately from the CUL Hospital Indemnity policy. **Applicant's Initials** _____

6) I understand that the **CUL THE PROTECTOR ACCIDENT POLICY Form #AC02-A is NOT Guaranteed Issue,** and must be applied for and be underwritten separately from the CUL Hospital Indemnity policy.

Applicant's Initials _____

7) I represent that I have answered all questions on the application(s) and on this form truthfully and completely, to the best of my knowledge and belief. I have, to the best of my recollection, fully disclosed all health history on myself or any other family members listed on the application(s), and I understand that this agent has no authority to waive or modify any answer to any health question(s). **Applicant's Initials** _____