

AUTHORIZATION TO MY BANK**CHECK-O-MATIC AUTHORIZATION**

**Attach Voided Check or Deposit Ticket Here
and Sign Authorization**

Bank Information

Name _____

City _____

State _____

Zip _____

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of Standard Life and Accident Insurance Company, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check 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 receive such notice I agree that you shall be fully protected in honoring any such checks. I further agree that should any such checks or electronic debits 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 Signed _____



Signature (as it appears on bank records) _____

Complete for Savings Accounts only if no personalized savings deposit ticket is available.

Account Number _____

Routing Number _____

CANAPP04

CANCER COVERAGE APPLICATION

ASSOCIATION MEMBER

Standard Life and Accident Insurance Company

An Oklahoma Corporation

 Administrative Office: P.O. Box 1870 Galveston, TX 77553-1870
888.350.1488

CANAPP04

ST-1386



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 888.350.1488

CANCER COVERAGE APPLICATION — ASSOCIATION MEMBER

Please Print — Use Black Ink I, as an association member, am applying for cancer coverage Basic Master

SECTION A

1. Please print the full name of all family members who are applying for coverage under this plan (include maiden name).
 (Use additional sheet and attach if needed)

Last, First, Middle Initial	Relationship	Sex M/F	Birthplace	Date of Birth Month, Day, Year	Age
A.	Applicant				
B.	Spouse				
C.					
D.					
E.					

2. Home Address _____ City _____ State _____ Zip _____
 Phone: Home (____) _____ Best time to call: _____ a.m. p.m.
 Phone: Work (____) _____ Best time to call: _____ a.m. p.m.
 Phone: Cell (____) _____ Email Address _____
 Billing Address (if different) _____ City _____ State _____ Zip _____

SECTION B

3. Has any person listed in Section A above ever been treated for or diagnosed as having:
 (a) cancer, other than skin cancer? Yes No (c) leukemia, lymphoma or other blood origin cancer? Yes No
 (b) malignant melanoma? Yes No (d) Hodgkin's Disease? Yes No

If Yes, please identify such person(s) by listing full name and birthdate below:

_____ Birthdate _____ Full Name _____ Birthdate _____
 _____ Birthdate _____ Full Name _____ Birthdate _____

SUCH PERSON(S) ARE AUTOMATICALLY EXCLUDED FROM COVERAGE UNDER THE POLICY.

4. Has any person listed in Section A, within the past 10 years, been treated for or diagnosed as having skin cancer, other than malignant melanoma? Yes No

If Yes, please identify such person(s) by listing full name and birthdate below:

_____ Birthdate _____ Full Name _____ Birthdate _____
 _____ Birthdate _____ Full Name _____ Birthdate _____

SUCH PERSON(S) ARE AUTOMATICALLY EXCLUDED FROM COVERAGE FOR SKIN CANCER.

SECTION B (continued)

5. Is the certificate for which you are applying intended to replace or change any of your existing accident and sickness coverage? Yes No

If Yes, identify the insurance plan, the name of the company and the person covered under such plan along with the date such insurance is to be discontinued. (Use additional sheet and attach, if needed.)

Insurance Plan	Name of Company	Person(s) Covered	Discontinuation Date

SECTION C

ATTENTION APPLICANT — After the application has been completed, and before you sign it, reread it carefully to be certain that all information has been properly recorded.

I understand that no benefits are payable for any cancer diagnosed in the first 30 days after the effective date of this certificate. I also understand that persons in Question Number 3 are excluded from coverage under the certificate, and that persons listed in Question Number 4 are excluded from coverage for skin cancer.

ACKNOWLEDGMENT — If eligible for Medicare, I have received the *Guide to Health Insurance for People with Medicare* and the Important Notice to Persons on Medicare.

FRAUD WARNING — Any person who knowingly, and with intent to injure, defraud or deceive any insurer, submits an application for insurance or makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of a felony.

APPLICATION DECLARATION AND AGREEMENT

I, the undersigned Applicant, and spouse if any, have personally completed this application and represent that the answers and statements in Sections A and B on this application are true, complete and correctly recorded and agree they will be used to determine my/our eligibility for coverage under the health insurance plan (the Plan). I understand and agree that: **1.** "Applicant" means all persons named in Questions 1 through 5; **2.** all statements and answers in this application and in any supplements or amendments to it are complete and true; **3.** any incorrect or incomplete information on this application may result in loss of coverage or claim denial; **4.** no insurance shall take effect unless the certificate is issued (or, if this application is made to change an existing policy or certificate, unless the change is approved) and the certificate is actually delivered to the Applicant and the first full premium paid during the lifetime and good health of all Applicants. I will notify and provide the Company with any evidence required by it to determine my future eligibility under the Plan.

I understand and agree that:

- 1. eligibility for the Plan does not constitute initial coverage under the Plan; and
- 2. initial coverage under the Plan is subject to the Company's underwriting criteria.

Dated at _____
City, State

Applicant's Signature

Date _____

Spouse's Signature

SECTION D

ADMINISTRATIVE SECTION

6. PREMIUM DATA

a. Billable Premium \$ _____

b. Amount of Premium paid with this application \$ _____

c. Mode: Annual Semi-Annual Quarterly Monthly COM

d. Method: Direct
 Salary Deduction

Franchise Name _____

Franchise Number _____

I have inquired about and have personal knowledge of the medical history of each Applicant.

Agent's Name _____
(please print)

Agent's Code _____

Phone () _____ Fax () _____ Email Address _____

Agent's Signature _____

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any: physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policyholder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on STANDARD LIFE AND ACCIDENT INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other Applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Applicant(s). It is understood that STANDARD LIFE AND ACCIDENT INSURANCE COMPANY underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it, resulting in loss of protection by federal regulations.

I understand that: **1.** such information will be used by STANDARD LIFE AND ACCIDENT INSURANCE COMPANY for underwriting and insurability determinations; **2.** I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain health insurance coverage; **3.** a picture copy or photocopy of this authorization shall be as valid as the original; and **4.** any authorized representative of the Proposed Insured is entitled to receive a copy of this authorization upon request.

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DISCLOSURE NOTICE**AGENT: THIS NOTICE MUST BE REMOVED AND LEFT WITH THE APPLICANT**

In connection with your application, Standard Life and Accident Insurance Company, or its reinsurers, may obtain medical and other information for evaluation purposes. Standard Life may obtain that information from the Medical Information Bureau, Inc. or any medical professional, medically related facility, insurance support organization or insurance company who possesses information about the care, treatment or advice given you or your family. That information could concern drugs, alcoholism or mental illness. Standard Life may also obtain an investigative consumer report on you.

Information regarding your insurability will be treated as confidential. Standard Life or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

Standard Life or its reinsurers may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

If an investigative consumer report is prepared in connection with your application, you may request to be interviewed for that report. Also, you have the right to review and note any corrections concerning reported personal information in Standard Life's file, unless the information is privileged.

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DISCLOSURE NOTICE (continued)

This notice is only a summary. You may request additional information about Standard Life's information collection practices and your rights by contacting Standard Life.

STANDARD LIFE AND ACCIDENT INSURANCE COMPANY

P.O. Box 1820

Galveston, Texas 77553-1820

Telephone Number: 888.350.1488

RECEIPT

CHECK OR MONEY ORDER FOR INITIAL PREMIUM MUST ACCOMPANY APPLICATION. ALL CHECKS AND MONEY ORDERS MUST BE PAYABLE TO STANDARD LIFE AND ACCIDENT INSURANCE COMPANY. If a

certificate is not issued, the initial premium will be refunded to the Applicant. If a certificate is issued, coverage will begin on the date of issue shown in the certificate.

Received from _____

on _____
Date

an application for Plan _____

and a Check Money Order for \$_____

Applicant's Signature _____

Agent's Signature _____

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION (continued)

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, P.O. Box 1991, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

Signed at: _____
City and State

Date

Applicant's Signature

Spouse's Signature (if coverage is requested for spouse)

Witness

Personal Representative designated by signature above is hereby authorized to execute this instrument based on: (circle one) power of attorney, guardian-in-fact, guardian, payee representative or other _____.

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