



Standard Life and Accident Insurance Company
 An Oklahoma Corporation
 Administrative Office: P.O. Box 1870, Galveston, TX 77553-1870
 888.350.1488

RECOVERY CARE II APPLICATION - ASSOCIATION MEMBER (Please Print - Black Ink)

SECTION A

1. Applicant _____ Date of Birth _____ Age _____
First Name Middle Initial Last Name
 Home Address _____ City _____ State _____ Zip _____
 Phone (____) _____ Best Time to Call _____ Email _____
2. Billing Address (if different) _____ City _____ State _____ Zip _____
3. Height _____ Weight _____

SECTION B

- New Policy Reinstatement
4. Male Female
5. **I, AS A MEMBER OF THE NCAA, AM APPLYING FOR:**
- a) Daily Benefit \$ _____ b) Lifetime Maximum Benefit Period (days): 180 270 360
- c) Elimination Period (days): 0 20 d) Inflation Protection Rider: Compound Simple
6. **Payment Mode:** Annual Semi-Annual Quarterly Monthly PAC
7. **Requested Effective Date:** _____

SECTION C

- If the answer to any question in Section C (8-11h) is Yes, the application should not be submitted.**
8. Are you now bedridden, confined to a nursing home, assisted living facility or hospital, or receiving the services of a home health care agency? Yes No
9. Within the past **10 years**, have you been treated for or diagnosed by a medical professional as having acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection? ... Yes No
10. Within the past **2 years**, have you:
- a) had or been recommended to have medical tests or treatment or surgery which have not been done or for which results have not been given? Yes No
- b) been hospitalized 2 or more times or confined to a nursing home or required assistance or supervision by another person for dressing, eating, personal hygiene (bathing or toileting), walking or transferring to or from a bed or chair or suffered a fracture of the spine or hip? Yes No
- c) required the use of a wheelchair, walker or cane? Yes No
- d) been advised to have cataract surgery or other eye surgery that has not been performed? Yes No

RCAPP08

(Turn over to continue)

Ins-Special, Inc
7505 State Hwy 37 / PO Box 218
Purdy, MO 65734
service@insspecial.com
800-789-0182

11. Do you now have or within the past **2 years** have you had or been advised to have treatment, surgery or to take prescription medication for:
- a) cancer (excluding basal or squamous cell), Hodgkin's disease, leukemia, or melanoma; even if the conditions are in remission? Yes No
 - b) congestive heart failure, coronary artery disease, peripheral vascular disease, circulatory disorder, heart disease, enlarged heart, transient ischemic attack, stroke, heart or heart valve surgery, angioplasty, pacemaker, or stent placement? Yes No
 - c) uncontrolled or insulin dependent diabetes, amputation or eye disease due to diabetes, chronic cystitis, Addison's disease, kidney failure, nephritis, renal insufficiency or kidney dialysis or gangrene? Yes No
 - d) emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), chronic obstructive lung disease (COLD), or any chronic pulmonary disease requiring the use of oxygen?..... Yes No
 - e) ulcerative colitis, Crohn's disease, cirrhosis of the liver, hepatitis or any disease of the pancreas or prostate not cured by surgery or treatment? Yes No
 - f) Paget's disease, rheumatoid or disabling arthritis, lupus or other bone or connective tissue disorder? Yes No
 - g) mental or nervous disorder requiring psychiatric treatment, organic brain disorder, Alzheimer's disease, ALS (Lou Gehrig's disease), muscular dystrophy, myasthenia gravis, Parkinson's disease, multiple sclerosis, cerebral palsy, epilepsy, neuropathy, paralysis, senile dementia or other senility disorders or alcohol or drug abuse?..... Yes No
 - h) incontinence, any ostomy present due to disease, an organ transplant other than corneal? Yes No
12. Within the past **2 years**, have you consulted a physician, been diagnosed or received treatment for any condition not listed above, including dizziness, vertigo, tremors, seizures, depression, anxiety, amputation, arthritis, asthma, osteoporosis, urinary incontinence, heart rhythm disorders, heart bypass or heart attack?..... Yes No
- If Yes, give information regarding diagnosis or condition. (use additional sheet if necessary) _____

SECTION D

Will any health, recovery short term, long term, or home health care insurance be replaced with this certificate? Yes No

If Yes, which company? _____ Policy Number _____

If Yes, read and complete the Notice to Applicant Regarding Replacement.

SECTION E

AGREEMENT — I have read or had read to me my completed application. My answers are true and complete to the best of my knowledge and belief. I understand my coverage, if issued, will begin on the date of issue shown in my certificate. I realize any false statement or misrepresentation in my application may result in loss of coverage under my certificate.

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.

ACKNOWLEDGMENT — If age 65 or older, I have received the guide *Medicare & You* and a Duplication of Medicare Coverage form from the Agent.

The certificate provides limited benefits. Review your certificate carefully.

Applicant's Signature _____ Date _____

City _____ State _____ Zip _____

A TELEPHONE INTERVIEW WILL BE CONDUCTED.

What will be the best time to contact the Applicant for the telephone interview? _____

**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.

(Turn over to continue)

**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.*

Date

Applicant's Signature

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



AUTHORIZATION TO MY BANK

PRE-AUTHORIZED CHECK AUTHORIZATION

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

Checking Savings

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 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 if no personalized deposit ticket is available.

Account Number _____

Routing Number _____

AGENT'S STATEMENT

I certify that: 1) I saw the Applicant; 2) I asked the Applicant the questions in the application and truthfully and accurately recorded the answers; 3) the answers did not conflict with my observations and knowledge of the Applicant; 4) I witnessed the Applicant's signature; and 5) If applicable, I gave the guide *Medicare & You* and a copy of the appropriate form(s) and/or disclosure(s) to the Applicant.

I also certify that: 1) the Applicant has read, or had read to him or her, the completed application; and 2) the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the certificate.

I certify that I have verified the Applicant's identity by viewing a U.S. federal or state government-issued I.D.:

Driver's License Passport
 Government-issued Identification Card Other

The company names, policy/certificate numbers and types of coverages of any other health insurance policies that I sold to the Applicant and which are currently in force are (if none, write "NONE"):

The company names, policy/certificate numbers and types of coverages of any other health insurance policies that I sold to the Applicant during the last 5 years and which are not currently in force are (if none, write "NONE"):

As the Agent, do you have any knowledge or reason to believe that replacement of existing insurance may be involved?..... Yes No

AGENT INFORMATION

Name (printed) _____

Signature _____

Agent Code _____

Date Signed _____

Phone _____ Fax _____

Email _____

Premium Quoted \$ _____ Premium Collected \$ _____

Receipt Given: Yes No Mail Policy to: Insured Agent
 No money collected. Initial premium is to be drafted.

Special Requests: _____

Ins-Special, Inc
7505 State Hwy 37 / PO Box 218
Purdy, MO 65734
service@insspecial.com
800-789-0182

NCAA

National Consumer's Advantage Association
16467 Chesterfield Airport Road, Chesterfield, MO 63017



Yes, I want to be a member of NCAA

Please Choose One:

- Bronze Level (\$1.00 per month or \$12 annually)**
- Silver Level (\$2.50 per month or \$30 annually)**
- Gold Level (\$4.50 per month or \$54 annually)**

Under the Bylaws of the Association now or as amended, with resulting cost savings that ultimately benefit me as a member, by delivery of this signed enrollment form to National Consumer's Advantage Association, I appoint its President as my proxy irrevocably to vote and otherwise act. This proxy shall be of no effect at any meeting that I personally attend. I agree to comply with the Bylaws of the Association during my membership enrollment and during the term of my membership in the Association.

Date _____

Print Name _____

Signed _____

Phone _____

Address _____

City _____

State _____ Zip _____

Dues will be included in your regular premium notices.

Dues are waived the first month.

Form NCAA04

Ins-Special, Inc
7505 State Hwy 37 / PO Box 218
Purdy, MO 65734
service@insspecial.com
800-789-0182

DISCLOSURE NOTICE

In connection with your application, Standard Life and Accident Insurance Company (Standard Life), 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.

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
888.350.1488

RECEIPT

IF PREMIUM IS COLLECTED, 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 coverage is not issued, the initial premium will be refunded to the Applicant. If coverage is issued, it will begin on the date of issue shown in the certificate.

Received from _____

on _____
Date

an application for _____ Recovery Care II _____

and a Check Money Order

for \$ _____

Applicant's Signature

Agent's Signature



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